The POLICY Project

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Post-Cairo Reproductive Health Policies and Programs:

A Comparative Study of Eight Countries

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Preface

The goal of the POLICY Project is to create supportive policy environments for family planning and reproductive health programs through the promotion of a participatory policy process and population policies that respond to client needs. The project has four components—policy dialogue and formulation, participation, planning and finance, and research—and is concerned with crosscutting issues such as reproductive health, HIV/AIDS, gender, and intersectoral linkages.

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POLICY Occasional Papers are intended to promote policy dialogue on family planning and reproductive health issues and to present timely analysis of issues that will inform policy decision making. The papers are disseminated to a variety of policy audiences worldwide, including public and private sector decision makers, technical advisors, researchers, and representatives of donor organizations.

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The authors gratefully acknowledge the contribution of all the people who were interviewed for the case studies. Each interview required an hour of the respondent's time, although some respondents graciously devoted more. Many of the questions required thought and discussion of events that happened several years ago. The respondents also passed along many documents such as written policies, studies, and implementation plans pertaining to reproductive health. We appreciate the assistance of POLICY staff and others in facilitating the interviews for the case studies. We would like to thank Tom Merrick, Janet Smith, and Nancy McGirr for reviewing drafts of this paper. We would also like to thank our USAID/W colleagues Barbara Crane and Elizabeth Schoenecker for their support and review of the reproductive health case studies. The views expressed in this paper, however, do not necessarily reflect those of USAID.

Executive Summary

The International Conference on Population and Development (ICPD) held in Cairo in 1994 intensified the worldwide focus on reproductive health policies and programs. Officials in many countries have worked to adopt the recommendations in the ICPD *Programme of Action* and to shift their population policies and programs from an emphasis on achieving demographic targets for reduced population growth to a focus on improving the reproductive health of their population. This paper presents information from case studies carried out in Bangladesh, India, Nepal, Jordan, Ghana, Senegal, Jamaica, and Peru to assess each nation's process and progress in moving toward a reproductive health focus.

The case studies show that within their unique social, cultural, and programmatic contexts, the eight countries have made significant progress in placing reproductive health on the national health agenda. All countries have adopted the ICPD definition of reproductive health either entirely or in part. Policy dialogue has occurred at the highest levels in all countries. The countries have also achieved considerable progress in broadening participation in reproductive health policymaking. Bangladesh, Senegal, and Ghana have been particularly effective in involving NGOs and civil society organizations in policy and program development. In some of the other countries, however, the level of participation and political support for reproductive health may not be sufficient to advance easily to the next crucial stage of implementation.

The case studies indicate almost uniformly that countries are grappling with the issues of setting priorities, financing, and implementing reproductive health interventions. Bangladesh has made the greatest progress in these areas while India, Nepal, Ghana, Senegal, Jamaica, and Peru are beginning to take steps toward implementation of reproductive health activities. Jordan continues to focus primarily on family planning. Several challenges face these countries as they continue to implement reproductive heath programs. These challenges include improving knowledge and support of reproductive health programs among stakeholders; planning for integration and decentralized services; strengthening human resources; improving quality of care; addressing legal, regulatory, and social issues; clarifying the role of donors; and maintaining a long-term perspective regarding the implementation of the ICPD agenda.

Despite many encouraging signs, limited progress has been achieved in actually implementing the *Programme of Action;* this finding is neither surprising nor unexpected. It took more than a generation to achieve the widespread adoption and implementation of family planning programs worldwide, and that task is far from complete. The key to continuing progress lies in setting priorities, developing budgets, phasing-in improvements, and crafting strategies for implementation of reproductive health interventions.

Abbreviations

AIDS	acquired immune deficiency syndrome
ANM	auxiliary nurse midwife
ASBEF	Association pour le Bien-Etre Familial
CONAPO	National Population Council
COREPOs	Regional Population Council
DPRH	Directorate of Human Resources Planning
EPI	Epidemiology Unit
FP	family planning
GNP	gross national product
HIV	human immuno-deficiency virus
HPSS	Health and Population Sector Strategy
ICPD	International Conference on Population and Development
IEC	information, education, and communication
IPPF	International Planned Parenthood Federation
IUD	intrauterine device
JAFPP	Jordan Association for Family Planning and Protection
MCH	maternal and child health
MFEF	Ministry of Women, Children, and Family
MINSA	Ministry of Health (Peru)
MOH	Ministry of Health
MOHFW	Ministry of Health and Family Welfare
MOHHC	Ministry of Health and Health Care
MSAS	Ministry of Public Health and Social Action
NAC	National AIDS Committee
NACO	National AIDS Control Organization
NCASC	National Committee for AIDS and STD Control
NGO	nongovernmental organization
NPC	National Population Council
PAC	postabortion care
PAHO	Pan American Health Organization
PAIP	Programme of Priority Actions and Investments on Population
PHC	primary health care
PIOJ	Planning Institute of Jamaica
PPAG	Planned Parenthood Association of Ghana
PPCC	Population Policy Coordinating Committee
PROCETSS	Program for the Control of STDs and AIDS
PROMUDEH	Ministry for the Promotion of Women and Human Development
RCH	reproductive and child health
RH	reproductive health
RTI	reproductive tract infection
SANFAM	Santé et Famille
STD	sexually transmitted disease
STI	sexually transmitted infection
UNFPA	United Nations Population Fund
USAID	United States Agency for International Development
WHO	World Health Organization

1. Introduction

The International Conference on Population and Development (ICPD) held in Cairo in 1994 intensified the worldwide focus on reproductive health policies and programs. Officials in many countries have worked to adopt the recommendations in the ICPD *Programme of Action* and to shift their population policies and programs from an emphasis on achieving demographic targets for reduced population growth to a focus on improving the reproductive health of their population.

This paper presents information from eight country case studies conducted to assess the process used and progress made in moving toward a reproductive health focus. The case studies were carried out in Bangladesh, India, Nepal, Jordan, Ghana, Senegal, Jamaica, and Peru. The purpose of the case studies was to describe the policy environment for reproductive health and the role played by the 1994 ICPD in sparking and shaping policies and programs in reproductive health.

The paper shows that much progress has been made in developing reproductive health policies based on the ICPD definition of reproductive health. The ICPD *Programme of Action* did not, however, provide a blueprint for implementing comprehensive, integrated reproductive health services. Countries are working to define priorities based on available resources. Less has been accomplished in terms of implementing integrated reproductive health programs—although services related to many of the elements of reproductive health are available in many of the countries. Several challenges face these countries as they continue to implement reproductive health programs, including improving knowledge and support of reproductive health programs among stakeholders; planning for integration and decentralized services; strengthening human resources; improving quality of care; addressing legal, regulatory, and social issues; clarifying the role of donors; and maintaining a long-term perspective regarding the implementation of the Cairo agenda.

2. Methodology

The case studies were conducted through in-depth interviews with 20 to 35 key individuals in each country in the areas of population and reproductive health. The respondents included representatives from government ministries, parliaments, academic institutions, nongovernmental organizations (NGOs), women's groups, the private sector, donor agencies, U.S. technical assistance organizations, and health care staff. Not all groups were represented in each country case study. The interview guide included the definition of and priorities for reproductive health; how reproductive health policies have been developed; the committees or structures responsible for reproductive health policy development, including the level of participation from various groups; support of and opposition to reproductive health; the role of the private sector and NGOs; how services are being implemented; national and donor funding for reproductive health; and remaining challenges to implementing reproductive health policies and programs. Interviews focused on the sections of the interview guide where the respondent had knowledge and expertise. POLICY staff or consultants served as interviewers for the case studies and reviewed published materials as appropriate. The fieldwork for the case studies took place between July and December 1997. The content of the case studies is based mainly on the expert opinions of the 20 to 35 interviewees in each of the eight countries and reflects the situation at the time of the interviews. All of the countries have continued to make progress in implementing reproductive health programs since then.

3. Reproductive Health Context in the Eight Countries

The context of reproductive health differs considerably in the eight countries, which span four regions: Asia (Bangladesh, India, and Nepal), the Near East (Jordan), Africa (Ghana and Senegal), and Latin America and the Caribbean (Peru and Jamaica). The countries range in population size from 2.6 million on the island of Jamaica to nearly 1 billion in India (see Table 1). Urbanization varies considerably among the countries. Ten percent of Nepal's population lives in urban areas compared with 78 percent of Jordan's population. Per capita gross national product (GNP) ranges from a low of US$200 in Nepal to $2,310 in Peru. Females comprise less than one-third of the labor force in Jordan, Peru, and India while about one-half of the labor force in Ghana is female. Adult female literacy ranges from 14 percent in Nepal to 89 percent in Jamaica. With the exception of Jamaica, female literacy is lower than male literacy; the gap is largest for women in Nepal.

Women in Jamaica have 2.6 children on average in their lifetime (the total fertility rate) compared with women in Senegal, who have six children. Contraceptive prevalence among women of reproductive age in union ranges from 7 percent of women in Senegal compared with 62 percent in Jamaica. The number of maternal deaths per 100,000 live births is lowest in Jamaica at 120 and highest in Nepal at 1,500 (see note 1 at bottom of Table 1). Infant deaths per 1,000 live births follow the same pattern; the rate is lowest in Jamaica at 24 and highest in Nepal at 79. Fewer than 10 percent of births are attended by health care staff in Bangladesh and Nepal compared with 86 percent in Jordan and 88 percent in Jamaica. HIV is beginning to pose a significant risk, particularly in India, Jamaica, Senegal, and Ghana.

In all eight countries, women tend to play a subordinate role to men, although in different ways and to varying degrees. Statistics on females' reproductive health status bear witness to the situation of women and to the different social, cultural, and economic contexts of people's lives in the eight countries.

Table 1. Reproductive Health Characteristics[1] of Eight Countries, Selected Years, 1990s

Item	Country							
	Bangladesh	**India**	**Nepal**	**Jordan**	**Ghana**	**Senegal**	**Jamaica**	**Peru**
Population (in millions, mid-1997)[2]	122.2	969.7	22.6	4.4	18.1	8.8	2.6	24.4
Urban population (percent, 1990s)[2]	16	26	10	78	36	43	50	70
Per capita GNP (US dollars, 1995)[3]	240	340	200	1,510	390	600	1,510	2,310
Labor force, female percent of total (1995)[3]	42	32	41	28	52	42	45	29
Adult literacy rate (1995)[3]								
Female	26	38	14	79	53	23	89	83
Male	49	65	41	93	76	43	81	94
Total fertility rate (1990s)[2]	3.6	3.5	4.6	5.6	5.5	6.0	2.6	3.5
Contraceptive prevalence rate[2] (Women of reproductive age in union, 1990-1996)								
Total	45	41	29	35	20	7	62	59
Modern	36	36	26	27	10	5	58	33
Maternal deaths per 100,000 live births (1990s)[2]	850	570	1,500	150	740	1,200	120	280
Infant mortality rate (1990s)[2]	77	75	79	36	66	68	24	55
Births attended by health staff[2] (in percent, 1990)	7	44	6	86	42	40	88	78
HIV prevalence[4] (data from cities, in percent, 1995)								
Low risk	0.0	2.5	0.0	--	3.2	1.7	0.7	--
High risk	1.2	28.6	1.3	--	5.2	10.1	24.6	--

Notes:

[1]For purposes of comparability, international sources were used for the information in Table 1. In some cases, more recent data are available for countries; these more recent data are reflected in the individual country reports.

[2]Population Reference Bureau. 1997. *World Population Data Sheet.*

[3]World Bank. 1997. *World Bank Development Indicators, 1997*.

[4] Bureau of the Census, HIV/AIDS Surveillance Database.

4. The Policy Process: Definitions of Reproductive Health, Policies, and Priorities

Among the eight countries, India was the first in the world to adopt a population policy (1952) while Ghana was the first country in Africa to do so (1969). Family planning—and more recently reproductive health—programs have developed at various paces, with different emphases on methods and services offered. The "Cairo process," which began a few years before the ICPD and continues to this day, helped some countries complete, consolidate, or revise policies related to reproductive health. Even though many countries began the process of shifting their policies and programs from family planning to reproductive health before the 1994 ICPD, each of the eight countries has now taken the definition of reproductive health from the ICPD *Programme of Action* as the basis for its national definition. The ICPD definition follows:

> Reproductive health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and its functions and processes. Reproductive health therefore implies that people have the capability to reproduce and the freedom to decide if, when and how often to do so. Implicit in this last condition are the rights of men and women to be informed and to have access to safe, effective, affordable and acceptable methods of family planning of their choice, as well as other methods of their choice for regulation of fertility which are not against the law, and the right to access to appropriate health care services that will enable women to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy infant. In line with the above definition of reproductive health, reproductive health care is defined as the constellation of methods, techniques, and services which contribute to reproductive health and well-being through preventing and solving reproductive health problems. It also includes sexual health, the purpose of which is the enhancement of life and personal relations, and not merely counseling and care related to reproduction and sexually transmitted diseases.

Six countries based their definitions of reproductive health on the comprehensive ICPD definition, although adoption of the verbatim definition does not mean that they have embraced and are working on all aspects of reproductive health. Most countries have attempted to set some priorities among the components of reproductive health. Family planning is clearly a top priority, followed by maternal and child health (MCH), STDs/HIV/AIDS, and reproductive tract infections (RTIs). Abortion and postabortion care are receiving increasing emphasis in some countries, as are programs for adolescents. Reproductive tract cancers and infertility are receiving little emphasis in the eight countries and, in most cases, gender-based violence is beyond the scope of the programs. Bangladesh, India, and Senegal have adopted the essential (or minimum) services package approach. The reproductive rights aspects of the ICPD *Programme of Action* have received significantly less attention than the health aspects. Table A1 in the appendix lists each country's policies related to the components of reproductive health.

Bangladesh. In Bangladesh**,** many policies address individual elements of reproductive health, although most of the policies were adopted before the 1994 ICPD. Policies cover family planning, maternal mortality reduction, MCH, nutrition, and breastfeeding. The major accomplishment of the ICPD was to induce policymakers to think in terms of an integrated approach to reproductive health rather than consider individual elements of reproductive health as vertical programs. Several new policies for individual reproductive health elements are under development, such as for STD/AIDS and emergency obstetric care. A number of task forces produced a draft comprehensive national reproductive health

strategy document in August 1997, which the government was reviewing and editing at the time of the case study.

Bangladesh has officially adopted the ICPD definition of reproductive health; however, the country's goal is to make reproductive health services available to all people through the provision of an essential services package. Priority services in the package include

- maternal health (including antenatal, delivery, and postnatal care; menstrual regulation; and postabortion complication care);
- adolescent health;
- family planning;
- management and prevention/control of RTIs, STDs, and HIV/AIDS; and
- child health, including an expanded program of immunization, acute respiratory infection, control of diarrheal diseases, and prevention of malnutrition (Ministry of Health and Family Welfare, 1997).

Ten task forces and a steering committee, established as a result of the ICPD, determined the services included in the essential services package. The package does not assign priority to any of its elements, although reproductive tract cancers and infertility receive less attention because these problems affect small numbers of people and are expensive to treat. Much of the primary infertility caused by RTIs will be addressed when protocols for STD/RTI treatment are implemented. Female genital mutilation is not practiced in Bangladesh. Gender-based violence is receiving attention in Parliament but outside the reproductive health policy arena.

India. The government of India supports the ICPD *Programme of Action*, as reflected in the 1992 Action Plan for Revamping the Family Welfare Programme in India. A representative of an international technical assistance organization said, "Cairo provided the global endorsement on reproductive health. The process started in India long before Cairo. Women's voices were loud and clear." The new approach in policy and programming for reproductive health has for the first time focused attention on client rights and choices. A government official commented, "After ICPD, we have furthered informed choice by removing the concept of center-driven targets for family planning. Cairo did influence our policies and programs, but India was aware of the problems linked with the target approach. ICPD pushed for change." In addition, a working committee, appointed before Cairo, reformed the *National Population Policy*. The policy exists in draft form, but components of it have been incorporated into the 1996 *Reproductive and Child Health Policy*. A journalist and women's activist commented, "We don't know if it is accepted by the current government. The main shortcoming of the document was that it did not provide details for implementation. It was a pro-woman and pro-development document but did not think through feasibility." India also has a draft youth policy.

One of the ICPD's most significant contributions has been the elimination of contraceptive method-specific targets, which is especially important for female sterilization procedures. India has defined a basic package of essential reproductive and child health (RCH) services that includes

- prevention and management of unwanted pregnancy, including abortion and family planning with sterilization services, social marketing, distribution of oral contraceptives and condoms, and provision of intrauterine devices (IUDs);
- maternity care, including prenatal, delivery, and postpartum services;
- child survival, including breastfeeding, nutrition, immunization, growth monitoring, acute respiratory infection detection and management, immunization, vitamin A supplementation, and diarrhea management; and

- prevention and management of RTIs/STDs, including detection by using the syndromic approach and antenatal screening for syphilis.

The RCH program will include all of these services and will attempt to increase quality and access while building service provision capacity among health care staff at the local level. For implementation purposes, family planning, child survival, and safe motherhood are priorities for all districts. After that, districts will add RTIs and STDs. The existing Child Survival and Safe Motherhood program addresses essential care for children, including immunization, management of diarrhea and pneumonia, and vitamin A supplementation. A population advocate said, however, "There is [no priority]; it's a very diffuse and ambiguous concept. We need to have some mechanism to prioritize. The government has not given much thought to this." Some reproductive health components, such as reproductive tract cancers and infertility, are receiving less attention because they are difficult and expensive to treat. Female genital mutilation is not practiced in India. Gender, which has mainly been the focus of NGOs that address women's issues, will be included in the RCH program through attention to quality of care issues, including improving the interaction between providers and clients.

Nepal. In 1983, the National Commission on Population drafted a population policy that formed the basis for the sections on population strategies within the seventh and eighth national five-year development plans. In 1991, the government adopted a *National Health Policy*, whose main objective was to expand preventive and curative health services to the rural population. The policy revamped the health service organization, abolished vertical programs, and called for a more integrated approach to service delivery. Following a national reproductive health workshop hosted by the World Health Organization (WHO) in 1996, the government drafted a reproductive health strategy. In 1994, the National Committee for AIDS and STD Control (NCASC), within the Ministry of Health (MOH), developed policies on HIV/AIDS/STDs and RTIs. Recently, the Planning Division of the MOH developed the *Second Long-Term Health Plan, 1997–2017*. The plan does not, however, reflect the integrated reproductive health care package outlined in the reproductive health strategy; instead, it talks only generally about a basic health care package.

The definition of reproductive health in Nepal follows the comprehensive definition from Cairo and includes all elements of reproductive health. The strategy paper for reproductive health also includes the ICPD definition. The integrated package developed at the 1996 WHO-sponsored meeting addressed the following elements:

- family planning;
- safe motherhood, including newborn care and prevention and management of complications of abortion;
- child health;
- RTIs/STDs/HIV;
- prevention and management of infertility;
- adolescent reproductive health;
- problems of elderly women; and
- reproductive tract cancers.

One donor representative said, "There are 15 different definitions of reproductive health." A respondent from a U.S. technical assistance organization remarked, "There is no real consensus around the definition of reproductive health; the WHO definition of reproductive health is different from what the UNFPA [United Nations Population Fund] supports." Until recently, no attempt had been made to set priorities for these reproductive health activities. An MOH respondent highlighted the importance of developing clear guidelines; he said, "The reproductive health policy has been conceptualized and intellectualized,

but no guidelines have been developed regarding how to approach services." In mid-1998, Nepal will go through a process to set priorities.

Jordan. During the early 1990s, the National Population Council (NPC) drafted the first *National Population Strategy*, which served as the basis for Jordan's delegation to the 1994 ICPD. In 1993, the Council of Ministers approved the *National Birth Spacing Policy*. While still not comprehensive, the policy reflects the government's desire to consider demographic variables in development planning. Jordan's 1993–1997 five-year development plan included population issues to be addressed through family planning programs based on birth spacing and the introduction of population issues into school curricula. In March 1996, the Council of Ministers approved the *National Population Strategy*. While the strategy does not incorporate all of the Cairo recommendations, the ICPD did have an effect on its development. At the end of 1997, the NPC had appointed a task force to revise the strategy to reflect the recommendations from the ICPD.

Jordan lacks a consensus definition of reproductive health. As one representative from an international technical assistance organization commented, "People have a vague idea of what reproductive health means." Respondents from the MOH were aware of the ICPD but did not embrace reproductive health as a new approach to the organization and delivery of services; in fact, high-level MOH respondents considered family planning a broader concept than reproductive health. Jordan's health programs cover several elements of reproductive health. Priority areas are birth spacing, safe pregnancy, well-baby care, and maternal and infant nutrition programs. Few respondents mentioned other reproductive health elements (e.g., STDs and reproductive tract cancers) as priority areas. Respondents noted that some reproductive health elements are not problems in Jordan, specifically AIDS (too few cases to be a priority), violence against women (thought not to be present or not brought to the attention of authorities), and female genital mutilation (nonexistent). At the time of the case study, two organizations were conducting reproductive health assessments to determine reproductive health priorities.

Ghana. In 1994 before the ICPD, Ghana revised its population policy, expanding it beyond family planning to cover reproductive health, the environment, and housing, among other areas. Although Ghana's policy predated the ICPD, it contains similar recommendations, particularly with respect to the MCH/family planning (FP) component. One NPC respondent explained, "Volume 2 (of the Action Plan) was MCH/FP, but it is really reproductive health. So we had jumped the gun for ICPD." Recommendations from the ICPD have been incorporated into new policies and implementation strategies and the action plans have been amended. One NPC staff member said, "If we developed a [comprehensive population] policy today, we would use all of the Cairo recommendations. But [instead of changing the 1994 policy] we have tried to implement it. What happened in Cairo was not explicitly stated in our policy document, this is only guidelines. We consider Cairo recommendations in coming up with strategies, for example, the IEC [information, education, and communication] strategy."

After the ICPD, the MOH undertook an assessment of health facilities to determine the information and services currently available for reproductive health. In reviewing existing guidelines, MOH respondents reported that parallel guidelines for STDs and MCH activities existed, with some guidelines contradicting one another. In addition, standards spelling out the responsibilities of health workers did not exist. Therefore, based on the recognition that the MOH and other service delivery organizations needed a separate policy for implementation, government and nongovernment representatives developed the 1996 *Reproductive Health Service Policy and Standards*. In addition, as one NPC staff person explained, "We thought adolescent reproductive health needed a special focus, and we developed the [reproductive health] policy further." The *Adolescent Reproductive Health Policy* is linked to the 1992 constitution and 1994 *National Population Policy*, which note the government's responsibility toward young people. The *Adolescent Reproductive Health Policy* addresses issues in addition to health, such as employment and education, and does not concentrate on services.

While Ghana has adopted the definition of reproductive health from the ICPD, several respondents said that the country was already focusing on reproductive health issues before Cairo. One government respondent said, "Post-ICPD? We were lucky to have a vision before 1994." Respondents mentioned, however, that the ICPD pushed policies and programs further in the direction of reproductive health. An MOH respondent said, "There is a difference between MCH and reproductive health. Reproductive health talks about everybody: men, women, children, youth. I still say women will be the focus because they bear the brunt of the illnesses." Several respondents echoed the continued focus on women. Respondents agreed that services for adolescents and HIV/AIDS are priority issues in Ghana. An NPC staff member commented, "There is lots of focus on adolescent reproductive health because it was identified as a priority in Cairo and Beijing. We see kids on the streets selling things. The number of adolescents, the jobs needed, the potential for HIV. You can see the problems clearly." A representative from the AIDS Control Program stated, "AIDS is a priority because of prevalence. Currently, it is estimated at 4 to 5 percent for HIV and, if the trend continues, it will be 8 percent by the year 2005." An MOH official said that safe motherhood, family planning, and STDs are priority areas for the MOH in addition to adolescent services. The official explained, "These [priorities] are determined by indicators. The maternal mortality and infant mortality rates are so high. We don't know the prevalence of STDs, but we see HIV increasing, so we know there are problems with STDs. So we have data to tell us. With family planning, the fertility rate is so high that we want to bring it down." Female genital mutilation is not a priority issue for the MOH or NPC mostly due to lack of resources to devote to it in the face of more pressing issues.

Senegal. Senegal has developed several different plans that address different aspects of reproductive health, including the *Programme of Priority Actions and Investments in Population, 1997–2001* and the *National Health Development Plan*. Many of these plans overlap, although each has its own focus. The PAIP was developed in 1996–1997 under the Directorate of Human Resources Planning (DPRH) in the Ministry of Economy, Finance, and Planning. It has three parts: population and development strategies, a national program for reproductive health, and advocacy/IEC. Together, these three "pillars" constitute the most comprehensive reproductive health plan for the country. They reflect the elements of reproductive health programs contained in other plans. The first and third pillars are the responsibility of the DPRH while the second is the responsibility of the Ministry of Public Health and Social Action (MSAS).

Perhaps because family planning programs are less well established in Senegal than in many countries, reproductive health is a new concept adopted in response to the ICPD. UNFPA, instrumental in promoting and clarifying the concept, has sponsored a series of workshops throughout the country to explain reproductive health. When asked to explain the definition of reproductive health in Senegal, most respondents replied, "The definition of reproductive health in Senegal is based on the recommendations from ICPD." Questions about reproductive health policies and programs usually generated a discussion of family planning policies and programs; respondents furnished information about other elements of reproductive health such as STDs and AIDS, maternal health, or female genital mutilation only when specific questions addressed these points. The elements of the ICPD *Programme of Action* concerned with reproductive rights and women's rights are less well accepted in Senegal than those associated with health. One government respondent said, "The family is the basic social unit in Senegal, and reproductive health is acceptable only when expressed in terms of the family."

The government has not established clear priorities in reproductive health. Its *Program of Priority Actions and Investments in Population, 1997–2001* (PAIP) proposes activities for all components of reproductive health, from male participation in family planning to female genital mutilation to breastfeeding. The program is impressively comprehensive but provides no indication of which among the vast array of proposed activities are priorities for the government. One respondent from a U.S. technical assistance organization described the PAIP as a "wish list" that the government is shopping

around to donors. A donor respondent said that for the government, "Everything has remained a priority." In 1991, the MSAS defined a minimum package of services that should be offered at each level of the health system (hospitals, health centers, and health posts); however, not all health structures provide the full package. The minimum package of services for health posts is

- primary curative consultation;
- prenatal care;
- well-baby consultation;
- vaccination;
- nutritional recuperation; and
- family planning.

In addition to health post activities, health centers should provide services for

- complicated deliveries;
- medical emergencies (intensive care);
- surgical emergencies;
- laboratory examinations; and
- radioscopy and radiography.

Jamaica. According to a government representative, "Revisions of the [1983] population policy started as a part of the Cairo process, including discussions of gender, the aged, children, and the environment and development." The 1995 (revised) *National Population Policy* did not make explicit reference to reproductive health. At the same time, the Population Policy Coordinating Committee (PPCC) developed the *National Plan of Action on Population and Development (1995–2015)*. The plan was designed "specifically to implement the objectives and recommendations of the revised *National Population Policy* and the *Programme of Action* of the …ICPD" (PIOJ, 1995). It includes a chapter on reproductive rights and reproductive health but is not a blueprint for action. While most statements indicate that Jamaica "should" undertake the recommended activities, they do not specify how.

The PPCC has discussed developing a reproductive health policy but has requested the National Family Planning Board (NFPB) and the MOH to submit a proposal for the policy. "There is a vision of how all these things should be, but no comprehensive policy on reproductive health, reproductive rights, and gender. Things are proceeding in a piecemeal way," according to a government representative. Until a comprehensive reproductive health policy is developed, specific components of reproductive health are covered under a number of policies, including the 1995 *National Population Policy*, the *National Plan of Action on Population and Development (1995–2015)*, the National STD/HIV/AIDS Program (developed in 1987 and now serving as a policy), the 1994 *National Youth Policy*, the 1994–1995 *National Policy for Family Life*, and the 1995 *Violence against Persons Act*. In addition, several policies are being drafted, including policies on adolescent reproductive health, senior citizens, and women (an update of the 1987 policy on women).

The ICPD definition of reproductive health is included verbatim in the *National Plan of Action on Population and Development (1995–2015)*, although respondents did not point to it as Jamaica's definition of reproductive health. Instead, the Family Planning Coordinating Committee (comprising representatives from the NFPB and the MOH) drafted a definition of reproductive health for Jamaica that is based on the ICPD definition. According to the draft definition, which was under discussion in late 1997, "No longer is the concern focused on family planning but a more holistic approach is being advocated which will involve

- meeting the needs of individuals and couples for a variety of safe and effective and affordable methods of fertility regulation from which they can make informed choice;
- reduction of pregnancy-related morbidity and mortality as well as reduction of newborn deaths and disabilities;
- prevention and management of reproductive tract infections, including HIV/AIDS and other sexually transmitted diseases; and
- provision of services for the early detection and management of cancers and other conditions of the reproductive tract.

Integral to this strategic change are the principles of dual protection, emergency contraception, and various gender issues. This approach encompasses the full life-cycle of men and women, although there is more emphasis on the vulnerable age group—the adolescent." This definition of reproductive health for Jamaica has not been widely shared within the country. Some government representatives were surprised to know that such a definition had even been drafted. Regardless of the definition of reproductive health and the status of the reproductive health policy, the main reproductive health priorities in Jamaica remain family planning and STD/HIV/AIDS, and the group to be targeted is adolescents. One government official worries that Jamaica is placing too much emphasis on adolescents, noting, "Program discussions of reproductive health now tend to shift to adolescents."

Peru. With most of the Cairo concepts already widely discussed in Peru before 1994, the ICPD represented part of a continuum. According to a university respondent, "The [Cairo] conference ratified what was already being done." Some respondents said that the 1995 Fourth World Conference on Women in Beijing had a much greater impact in Peru than did the 1994 ICPD, in part because President Alberto Fujimori personally attended the Beijing conference.

The primary plan for implementing reproductive health programs is the *Reproductive Health and Family Planning Program, 1996–2000* of the Social Programs Department of the Ministry of Health (MINSA). While this new program mentions interconnections with other components of reproductive health, it covers only the four components that make up the Social Programs Department: family planning, maternal and perinatal health, school and adolescent health, and cancer of the reproductive tract. Although designed exclusively by staff of the MINSA, the program is intended to be a global framework for all organizations working in reproductive health. The program's strategies for addressing reproductive health problems call for democratization of access to information in reproductive health and family planning; universal access to reproductive health and family planning services; decentralization and sustainability of reproductive health and family planning services; continuous improvement of the quality of care in reproductive health and family planning; intersectoral linkages; promotion of women's reproductive health; and development and implementation of the "Emergency Plan for the Reduction of Maternal Mortality."

Several respondents said that the new focus on reproductive health has led to a broader vision of the condition of women, highlighting issues such as gender equity and girls' education. MINSA's new reproductive health program defines reproductive health as a need that covers a woman's life from the time she is born, through childhood and adolescence, through her reproductive years, and on into old age.

The government's top reproductive health priority is undoubtedly family planning, but its support for maternal health is also increasing. Two respondents said that STDs and AIDS programs are underfunded, but concern is increasing among public-sector authorities about children infected with STDs and HIV and perinatal transmission. Postabortion care is not a significant part of the maternal health program. One MINSA respondent said that abortion is no longer as great a cause of maternal mortality as in the past, although the reasons for the change are unclear. Cancer is a relatively low government priority in part

because of the high cost of providing treatment. In principle, the MINSA program reflects many of the concepts of reproductive health as defined at the ICPD, but implementation lags behind policy statements.

NGOs focus heavily on gender issues, quality of care, reproductive rights, and sexual health. A USAID-funded project, REPROSALUD, has been working with rural women to encourage them to define their own priorities in reproductive health. In the project, according to one respondent, the overriding reproductive health concern identified by women is vaginal discharge, an issue not even on the agenda of most projects and programs.

5. Participation, Support, and Opposition

Among the eight case study countries, one positive outcome of the process that has accompanied the Cairo conference is the involvement of a wide range of stakeholders in the policy process. While governments have direct responsibility for policymaking, NGOs and other members of civil society organizations have also participated in the policy process to varying degrees. Leading up to the Cairo conference, some countries had stronger traditions of participation in policymaking and thus stronger NGOs and other civil society groups, including women's health advocates. In other countries, wider participation in policymaking is a more recent development. Respondents not affiliated with the government were more confident in some countries that the government values their views and incorporates them into policymaking. Still, even though countries have adopted policies designed to provide services through an integrated approach to reproductive health, some opposition remains in a number of the countries. The source of opposition is somewhat different in each country.

Bangladesh. At the national level in Bangladesh, health policymaking is increasingly participatory. The Ministry of Health and Family Welfare (MOHFW) is responsible for policymaking in the area of reproductive health; however, many participatory committees, task forces, and technical review committees collaborate with the MOHFW. One donor representative stated, "Everybody in Bangladesh is involved in policymaking—the government, the MOHFW, local governments, local government, rural development committees, donors, NGOs, the private sector, and everyone at the national level." A representative from a service delivery NGO commented, "Now that government organizations and the NGO sector are working together, the whole system has improved—health, family planning, and all sectors of development. This clearly illustrates that active participation is necessary." Participation in the policymaking process has not yet filtered down to local levels, however, even when local services are concerned.

Overall, there is widespread support for reproductive health policies and programs in Bangladesh. The opposition to reproductive health is limited to a few religious and women's groups. According to some respondents, the groups that oppose reproductive health are small, fractionated, and lacking in support and influence. Their opposition has tended to be targeted at family planning.

India. In India, the reproductive health program is sponsored and financed by the central government and implemented by the state governments. The Ministry of Health and Family Welfare (MOHFW) is responsible for setting policy for reproductive health and, in that capacity, works with a multisectoral committee of secretaries from ministries involved in population and development activities (Health and Family Welfare, Education, Women and Child Development, Rural Development, and Information and Broadcasting). Under the new program, similar committees will be formed at the state level.

Historically, NGOs in India have had little influence on the formulation of national policy, although this situation may be changing, particularly in reproductive health. NGOs serve only a small proportion of reproductive health clients and are weakest in the northern states. Nonetheless, several vocal women's NGOs have influenced reproductive health policy through their organizing and advocacy activities. They have been effective in stopping the introduction of injectable and implant methods in the Indian program. One donor representative noted, "After Cairo, there has been a definite improvement in representation of NGOs at the policy formation stage." At the same time, though, a respondent from a leading service delivery NGO commented, "NGOs are invited to forums for decision making with government; however, the government tends to be selective in the involvement of NGOs. The most vocal NGOs are not invited for policy discussions. Once the decisions have been made, the government may invite more NGOs to discuss implementation issues." A donor noted, "At the ICPD conference…the NGOs and the government communicated at a much better level—a new policy direction emerged. It has had more of an impact on rhetoric and the policy level in India with not much change at the programmatic level."

In India, policymaking has generally been conducted at the national level for reproductive health; however, with decentralization and recent legislation establishing village "*panchayats*" and city "*nagarpalikas*," there is hope that planning will take place at the local level. The new World Bank-funded Reproductive and Child Health (RCH) Project was designed for local-level decision making and implementation. One government official postulated, "Some awakening of the women's movement also came due to reestablishment of the *Panchayat Raj* at the village level." Most respondents believed, however, that true *panchayat* participation in policymaking would take some time. For example, the new law states that one-third of the *panchayats* must be composed of women; however, women are sometimes seen as figureheads elected to follow the orders of their husbands.

Some donors and population groups demonstrate a fair amount of opposition to the reproductive health approach while some women's groups oppose various elements of family planning. A population advocate stated, "Reproductive health is just a word—jargon. There is no Hindi equivalent of it. Reproductive health provides feminist groups with strong leverage to act in the country." A respondent from a population organization said, "The conventional emphasis on family planning is diluted. The government is throwing out its responsibility of addressing lower population growth because of the focus on reproductive rights. Family planning goals have been set aside, long-term goals have been set aside. The target-free approach was precipitated by Cairo. This approach is negative for India. In India, the population growth rate is still very high. India is still choking with population pressure." Some donors fear losing sight of the demographic objectives, saying that the decline in contraceptive use in some states is of grave concern.

Nepal. Two government agencies in Nepal share responsibility for developing policies relating to population and reproductive health: the MOH and the Ministry of Population and Environment. The level of participation among various groups in reproductive health policymaking in Nepal is generally low. The MOH, and to some extent reproductive health NGOs, participate in policy forums. Although international and local service delivery NGOs established an NGO Coordinating Council in 1995, the general perception among respondents was that NGOs and the government have not yet engaged in a fruitful collaboration. One NGO representative commented, "NGOs are not really involved in development of plans. Government does not truly consider the NGOs their partner. Such talk is jargon." An MOH official stated, "The NGOs try to replicate services where the MOH is already providing services. They should seek out areas where it is not feasible for the government to reach." Several respondents mentioned that the government and NGO partnership is not working because of higher salary structures within the NGOs, political instability, and the political decision of certain politicians to align themselves with certain NGOs.

Support for reproductive health among policymakers is generally considered to be low. Many respondents mentioned Nepal's political instability as a reason for parliamentarians' not wanting to take up new issues. A representative from a U.S. technical assistance organization mentioned, "There is lip service for reproductive health. At the political level there is no seriousness for this topic." An MOH respondent said, "The reproductive health policy is partly donor-driven; there is no opposition to the concept, but the government policy is not strong enough to enforce the strategy." There is even some evidence of lack of support for the reproductive health strategy within the donor community. One donor representative said, "The reproductive health Mafia—it does not allow anyone to criticize reproductive health. It does not allow any dissent." Some respondents felt particularly strongly that reproductive health is an inappropriate focus for Nepal at this time. Nepal is unable to provide even the most basic health care services to its people. Three ecological zones make service delivery a real challenge. An NGO respondent commented, "A reproductive health focus in Nepal can dilute the family planning program unless you build incrementally on what already exists."

Jordan. At the national level, Jordan tries to foster broad participation in population and reproductive health policymaking through the NPC, which counts NGOs and university representatives among its members. Jordan has used what one representative of a U.S. technical assistance organization called the "low-key technical approach" in which cautious advances in policy are the product of a small group's development of policy followed by the building of a wide consensus on the issues. For example, a task force of technical experts is revising the *National Population Strategy*. Subsequently, the NPC will generate support for the updated policy among policymakers. There is some concern, however, that the revision process for the strategy should be open to wider participation. The small task force does not have broad participation—its members are researchers and trained demographers, not representatives of grassroots organizations. Some respondents said that wider review could delay or halt the revision process due to diverse parties' conflicting ideas and interests. One representative from a U.S. technical assistance organization said, "NPC is charged with getting the strategy done. It is reluctant to open the process up too much because it could really slow it down."

In Jordan, religious leaders are highly respected and their opinions valued. At present, religious leaders are open to education on reproductive health matters for themselves and may even spread messages about family planning and reproductive health in their speeches and during private counseling. Even though the public has little knowledge of reproductive health, some respondents believed the general population would have little opposition to the idea of reproductive health once people understood the concept.

While support for family planning has been growing in recent years, Jordan lacks strong support for reproductive health. Several respondents noted that many physicians, particularly in rural areas, still oppose family planning and that their attitudes negatively affect policy implementation and service delivery. Particularly in remote areas, physicians' ideas are often taken as policy. For example, one respondent from a U.S. technical assistance organization noted that heads of rural health directorates often refuse to implement MOH policies if they do not support them. For reasons such as these, respondents stressed the need to develop service guidelines and enforce their implementation.

Ghana. The policy formulation process in Ghana is highly participatory at the national level. For example, government ministries and agencies, NGOs, private sector representatives, consultants, and donors were involved in the policy formulation process for the 1994 *National Population Policy*, the 1996 *Reproductive Health Service Policy and Standards*, and the *Adolescent Reproductive Health Policy* (in draft). In addition, the MOH and the NPC have attempted to involve all levels of their organizations in the process. One NGO representative said, "Yes, we have input. We attend regular [NPC] meetings according to the subject of the meetings...The process is quite open, and we can come in with our interests." An NPC staff member agreed, "Regarding policymaking, there is participation at all levels. All are involved: NGOs, etc.... For the 1994 *National Population Policy*, we worked with the MOH and

all stakeholders in health to develop the reproductive health component. We then took it out and developed it further and expanded it. We also took the policy to the regions because they have problems with implementation... We took a draft to the community to get their input and then revised the policy as final. So ownership was there." The MOH directed formulation of the 1996 *Reproductive Health Service Policy and Standards*, but a representative from a U.S. technical assistance organization said, "We were there at the workshop to review and gave our comments. It was a tedious process. There were different perceptions of people and the language used, but we got to a consensus."

Given that district leaders and district assemblies will be making planning and resource allocation decisions, their knowledge of reproductive health and support for it are crucial. Despite widespread support for population and reproductive health issues in Ghana at the national level, support does not reach the local level, which is important as Ghana decentralizes health services. Respondents believed the lack of support is due more to a lack of knowledge and awareness among regional and district-level policymakers and the public than to objections to population and reproductive health issues. One respondent from a U.S. technical assistance organization said, "People in Ghana are very forward-looking and willing to take chances. They are leaders in health and politics in Africa. Especially in the health sector, they are real leaders." Some religious groups may be opposed to specific issues (e.g., the Catholic Church to sterilization), but not to reproductive health in general. Respondents noted, however, that there is no sweeping support of reproductive health from any group. A respondent from a U.S. technical assistance organization noted, for example, "Chiefs and traditional leaders are no problem. In fact, chiefs are present [to receive family planning in the clinics]. They may not encourage it, but they are not against it."

Senegal. Most respondents in Senegal reported that the level of participation in reproductive health policy formulation is high, in part because of cultural traits that encourage open and lengthy discussion to arrive at consensus. One NGO respondent said, "The presence of NGOs is particularly pronounced in the area of health. The government integrates them in all programs and policies because they provide a lot of the services, and because it is pushed by donors." One respondent from a U.S. technical assistance organization remarked, "There is still a rivalry between the government and NGOs, but there is synergy." Respondents also said that NGOs participated fully in the development of the national reproductive health program and will play a major role in its implementation.

At the same time, several respondents commented that participation is limited to national and international NGOs and that community-level NGOs are not involved. An NGO respondent stressed the importance of grassroots participation: "If policies are to respond to the needs of the population, they must be involved from the beginning, which the state does very rarely." The private sector is not involved as a partner in reproductive health.

The perception that reproductive health is replacing family planning as a term and an approach elicits different reactions among respondents. Some said that with such high fertility and population growth rates, fertility reduction is an appropriate and important area of concern that may get lost in the new reproductive health focus. Several respondents expressed concern that reproductive health is "too vast." On the other hand, many respondents perceived an advantage in focusing on reproductive health. "Even if it is vague, it is at least more culturally acceptable than family planning." Gaining the support of religious leaders, or *marabouts*, is critical for the success of reproductive health programs and policies. As one respondent said, "Political leaders have only superficial influence; the souls of the people are with the *marabouts*." An important effort to gain religious leaders' support for reproductive health is the Islam and Population Network, which is made up of representatives from all the main religious sects. One activity of the network has been to produce a booklet that reviews Senegal's population policy and states its position based on the Koran. Thus, some religious leaders have become valuable allies in actively promoting some elements of reproductive health.

Many respondents expressed the view that political leaders have in recent years become particularly supportive of reproductive health. One donor representative noted that no West African president is more involved than President Diouf in supporting family planning and reproductive health. This respondent said, "I believe the government's commitment to reproductive health is sincere. They have developed all these plans and programs in reproductive health. What more could we ask of them?" At the same time, some respondents questioned the depth of commitment on the part of political leaders. While the leaders are at least not actively opposed to reproductive health, they are not especially proactive in advancing the reproductive health agenda. Another donor respondent said, "Cairo changed the rhetoric, but there is no change in the field—and there won't be, because the political commitment is very superficial. Some technicians are very committed, but not the people with political weight."

Jamaica. Three government agencies share responsibility for Jamaica's policymaking in the area of family planning and reproductive health: the Planning Institute of Jamaica (PIOJ), the NFPB, and the MOH. The various ministries are expected to implement the policies while a number of committees advise the government on specific components of reproductive health, most notably the PPCC and the National AIDS Committee (NAC). NGOs are included in consultative meetings and participate in some meetings of the PPCC; NGOs are included on the NAC. According to an NGO representative, "In meetings the government gets recommendations for policies. They do have representatives from NGOs. But what notice the government agencies take is another matter; hopefully, it goes where it should end up. I think there is an attempt to get broad representation."

Family planning (and more recently AIDS issues) has enjoyed strong support from the government for many years, and support has increased since the ICPD. An NGO representative noted, "Since Cairo, we don't have to fight with the government over the budget. We have the support of the highest levels of government." There is little opposition to family planning and reproductive health in Jamaica. Nonetheless, the topic of adolescent sexuality and reproductive health services for young adults brings out the most vocal opposition from some parents, teachers, administrators, and providers. A representative from an NGO observed, however, "There is more acceptance by parents now, due to HIV." Citing that 25 percent of births are to teenagers in Jamaica, a donor representative stated, "The statistics show that there is a need to work with adolescents age 15 to 24."

Peru. In Peru, most respondents agreed that over the past few years NGOs and the government have begun to work together more closely. A respondent from a U.S. technical assistance organization said, "Now, NGOs understand they can't replace the government, and the government understands it can't do it all alone." On the other hand, some respondents said that NGO influence has actually decreased in recent years. A donor respondent commented that the centralization of the government "does not lend itself to the enfranchisement of other groups." An NGO respondent added, "NGOs don't have much chance to have their voice heard." A university respondent commented, "Women's groups do not carry as much weight now as they did in the past." NGOs and the government seem to be working much more closely together at the regional level than at the national level. In regions with regional population councils, representatives of civil society organizations work with representatives of the government, providing one mechanism through which NGOs can have influence.

President Fujimori is a strong supporter of reproductive health, although a demographic viewpoint tends to prevail, notwithstanding the broader understanding of reproductive health that technicians within MINSA may have. The primary source of opposition to reproductive health as defined both at Cairo and by the Peruvian government is conservative elements within the political and religious spectrum. An NGO respondent emphasized the need "to create a culture of reproductive health," a solid foundation that goes beyond the agenda of any given government.

6. Policy Implementation

In all eight countries, policy formulation has received considerable attention in the three years since the 1994 ICPD; however, sound policies do not ensure that clients will receive comprehensive, high-quality, client-focused reproductive health services. Respondents in many countries said they had spent considerable time discussing reproductive health and that they were just initiating the implementation process. For example, a government representative from Jamaica said, "Most of what we've done since Cairo is meetings and conferences. It is taking a long time to understand these issues." Many respondents did say, however, that activities related to individual elements of reproductive health were continuing in their countries. Most said that the ICPD provided the impetus to design new programs or to redesign existing programs based on a client-centered, life-cycle approach that integrates reproductive health services. Policy implementation has involved various stakeholders, including government and NGOs, and has highlighted the need for coordination not only among the government, NGOs, civil society organizations, the private sector, and donors but also among government bodies (such as National Population Councils) and government ministries. This section focuses on activities either being planned or in place to develop, integrate, or link the components of reproductive health services. For each of the eight countries, Table A2 in the appendix outlines the status of implementation of the components of reproductive health.

Bangladesh. Bangladesh is revising many of its pre-Cairo projects and programs to focus on reproductive health and has already translated many of its reproductive health policies into operational guidelines. The MOHFW has collaborated with a number of groups to develop the *Health and Population Sector Strategy* (HPSS), which shifts from vertical projects to an integrated program approach providing an essential services package with a client-centered reproductive health approach that addresses women in particular. The government of Bangladesh submitted the HPSS to the World Bank in August 1997. In addition, the government's 1997–2002 fifth five-year plan is largely based on the HPSS. The two largest donors in Bangladesh (the World Bank and USAID) have also designed their assistance programs based on the HPSS. Currently, the public sector program is shifting away from doorstep services and is encouraging clients to obtain services at fixed clinic sites. Ministries and NGOs are adopting reproductive health elements as resources become available. Standards and protocols for service delivery are being revised to move away from goals and targets.

In Bangladesh, service delivery activities are divided between two bodies within the MOHFW—the Directorate of Family Planning and the Directorate of Health. The directorates have their own vertical service delivery structures, with collaboration and coordination between them weak at best. The bifurcation of the directorates has created many parallel systems. One donor representative stated, "This is a big issue. Dr. Nafis Sadik [Executive Director of UNFPA] made it clear to the prime minister that integration is crucial to the success of the reproductive health focus. We must integrate the health and family planning wings, and they must work together. Currently, the family planning wing is strong, but the health wing is weak. Our program will not remain successful if there is no integration. Many facilities are underutilized, and the different facilities and their staffs don't collaborate. How to integrate is a key issue." A representative of one U.S. technical assistance organization commented, "In the NGO system, they are trying to integrate all reproductive health elements, including postabortion care under [the essential services package]. I am hopeful that the government will also be able to achieve an integrated system."

In 1975, Bangladesh merged family planning with maternal and child health. According to respondents, the merger is one reason for the success of today's family planning program. Family planning and antenatal care services are integrated in most public sector facilities; indeed, some facilities provide both postnatal care and management of RTIs/STDs. Nonetheless, the government's plan is to integrate all

seven reproductive and child health elements of the essential services package at different levels of service delivery to enable people to receive all the routine services they need at one site. Respondents considered integration of services necessary for the successful implementation of the essential services package.

India. Despite the existence of a reproductive health policy and a technical strategy, many respondents questioned how India would implement its program. Within the MOHFW, three divisions are responsible for the implementation of the reproductive health programs: Family Welfare, Health, and the National AIDS Control Organization (NACO). The Family Welfare and Health divisions are responsible for all family planning and MCH services, while NACO is responsible for STD/HIV/AIDS programs. India has committed itself to several initiatives as a result of the ICPD. For example, the World Bank-funded RCH Project was designed to support India's response to implementing the ICPD *Programme of Action.* With a focus on the district level, the project is being implemented in selected districts. It relies on a district-based planning approach to create an integrated health delivery system. Evaluation will be linked to increases in utilization of services and decreases in infant and maternal mortality rates. Operational strategies are to be defined at the local level through primary health center planning and implementation in conjunction with the local *panchayats*, grassroots workers, and the community.

Several Indian states experimented with the "target-free approach," but targets were eliminated nationally in April 1996 (although some states still use targets) before the approach could be evaluated. In some places, elimination of targets led to confusion and work stoppages for family planning activities. One respondent said, "What the target-free manuals really mean is unclear and confusing to people at lower levels. How are the targets being replaced? There has to be some way of assessing performance. Many primary health care doctors feel that no targets mean no work." A donor representative noted, "In practice, target-free has meant no focus on sterilization. There is a greater need for a broader choice within contraception. Shifting to a broader range of services, such as an improved method mix, has not happened yet…. How do you overcome the target orientation? What is being done to achieve this? Some service upgrade and some training efforts. Is there a capability for RTI screening and treatment? There can be an unbelievable demand for such services. Is there the capacity to meet such need? The government was unable to meet the needs even within family planning…and now shifts to broader reproductive health service provision. Is it feasible?" Some states such as Andra Pradesh, Rajasthan, and Maharastra forged ahead with making their family planning programs more need-based and developed strategies to provide additional reproductive health services. The transition from a centrally controlled and top-down program to a program with more state control and bottom-up planning will require an adjustment period before it can be fully implemented and demonstrate a level of success.

India's basic package of essential RCH services is supposed to be delivered through integrated services. In many ways, the existing service delivery infrastructure has become increasingly integrated. In 1965, family planning was integrated with MCH and nutrition services; in 1992, the Child Survival and Safe Motherhood program integrated key child survival interventions with safe motherhood and family planning activities. The RCH Project will add RTIs/STDs and strengthen abortion services. Different services will be available at different facility levels and all services will be phased into states and districts according to a classification system. The referral system will be strengthened. Despite the high level of integration, vertical programs within the MOHFW still exist. As the primary STD/AIDS program, NACO has a separate delivery system of STD clinics. "Even within the health system there is a lack of integration. The integration efforts should first be directed within the MOH," a donor representative commented.

Nepal. The Family Health Division of the MOH has been chartered with implementing reproductive health programs in Nepal. The Family Health Division, however, is at the same level as other divisions of the Department of Health within the MOH, thus limiting its policy formulation and implementation

capacity. A respondent from a U.S. technical assistance organization recommended, "The organization responsible for formulating policies and implementing reproductive health programs should be at the level of the Director General of Health Services." Moreover, the *Reproductive Health Strategy* is particularly ambitious. A donor representative said, "As a rubric, reproductive health is dangerous. In countries that have strong family planning and AIDS programs, they can organize other reproductive health elements. In Nepal, it can further muddy waters."

Some aspects of the strategy are currently being implemented, including family planning, safe motherhood, and breastfeeding. One respondent from a U.S. technical assistance organization representative remarked, "All components of reproductive health are in place, but it does not function. Reproductive health cannot be a reality for Nepal at least below the district level. The FHD needs to determine which set of interventions it can realistically provide and highlight those that it cannot. They have to understand the difference between what is desirable and what is feasible." An MOH official stated, "Although the reproductive health package is outlined, there has been no decision to implement because of lack of willingness and lack of support." Another MOH official stated that it was the political instability that prevented implementation of the reproductive health strategy. An NGO representative remarked, "Translating policies into action has always been a problem in Nepal." Another NGO representative said, "It is not the lack of policies or laws—it is the enforcement that is a problem."

Under the 1991 *National Health Policy*, one subhealth post should be available for a population of 4,000, a health post for a population of 29,000, and a primary health care center for a population of 100,000. Nepal has only partially achieved the 1991 policy goal; moreover, 30 to 50 percent of existing health posts and subhealth posts have no health staff. A donor representative emphasized the problem by saying, "There are new institutions in the districts but staff is just not there." In addition, there are several donor-driven projects in safe motherhood, reproductive tract cancers, and HIV/AIDS, among others, but several respondents mentioned that donors have their own areas of emphasis within reproductive health. An NGO representative said, "Donors are pressing the government to accept their reproductive health approach. Donor coordination is very weak and there is no consensus on reproductive health among the donors." More than half the respondents stressed the need to set priorities within the reproductive health strategy and to develop a plan for the phased-in implementation of activities.

Jordan. The 1996 *National Population Strategy* functions as the main implementation plan for population policies at the national level; however, several donor respondents and representatives from U.S. technical assistance organizations pointed out that it "does not say what the government should do to reach the goals." It is not clear if the strategy, which is currently under revision, will serve as an action plan.

While about half of the respondents agreed that Jordan has experienced positive change because of Cairo, one respondent from a U.S. technical assistance organization observed, "ICPD made a big difference on policy debate, but it is questionable if it affected implementation and what will happen with implementation." A Ministry of Health and Health Care (MOHHC) respondent noted, "There is no difference in the offering of services before and after ICPD. Same services now as then. We need the infrastructure [to incorporate new services]. Myself, I see the need to integrate." While services for each component of reproductive health exist to some extent in the public, NGO, and private sectors, Jordan lacks an integrated (or even linked) reproductive health program.

With the establishment of MCH/family planning as independent directorate in 1993, the MOHHC has pushed to integrate all MCH centers (which were previously standalone centers) into comprehensive health centers; the process is near completion. Given that most women deliver in the hospital, the challenge, which one hospital-based project is trying to meet, is to link prenatal and antenatal care and family planning services (located in MCH centers) with delivery services (in hospitals). Other

reproductive health services, including STD/HIV diagnosis and treatment, postabortion care, reproductive tract and breast cancers, and infertility, are either not offered at all or are provided by another MOHHC directorate.

NGOs, the private sector, and the United Nations Relief and Works Agency for Palestinian Refugees are shifting to a reproductive health and family planning approach. The Jordan Association for Family Planning and Protection (JAFPP), which is an affiliate of the International Planned Parenthood Federation (IPPF), has started to introduce new services such as STD screening and management and information for youth, early detection of breast and cervical cancer, and limited infertility counseling. Respondents from several sectors reported that services are integrated in the sense that providers treat "whatever comes in"—there is no formal treatment or referral system for reproductive health services. This appears to be the case in most places for postabortion care, domestic violence, and even STDs and HIV. Most providers note that the large share of clients are married and at least in their 20s. Unmarried adolescents are not served; married adolescents are treated like any other client.

Ghana. While reproductive health policymaking has received considerable emphasis in the past several years in Ghana, implementation has only recently begun. Of the eight countries, Ghana has perhaps the most extensive "blueprint" for providing reproductive health services as outlined in the1996 *Reproductive Health Service Policy and Standards.* The guidelines are geared toward public, NGO, and private providers. According to an MOH respondent, "People wanted guidelines. The problem was lack of job descriptions and protocols. The policy spells out some of these things." A donor respondent was positive about the *Reproductive Health Service Policy and Standards.* "This is a policy about what to do. This is in better shape than other areas... The 'what to do' seems to be in place."

The 1996 *Reproductive Health Service Policy and Standards* document is undergoing wide dissemination. A regional MOH official said that regional representatives have been trained in the reproductive health policy and that these representatives disseminate the policy to further levels of users. He said, "Most of the time when a policy is formulated, it doesn't go down to the users... [This time], we will have a workshop to introduce all users formally." Health workers receive instruction about the policy during safe motherhood training. The private sector and NGOs have received the policy and are using it in their operations. In addition, in 1992 Ghana developed an AIDS guidelines document entitled *Guidelines for AIDS Prevention and Control*, as well as six action plans that accompany the 1994 *National Population Policy*.

Integrated services have developed over time in Ghana. Respondents noted that Ghana recognized early on that MCH services should be offered together. One MOH official said, "We have MCH. It started with this. Now we only need to add reproductive health activities." HIV/AIDS and STD management are now being added while midwives and physicians are receiving training in postabortion care. When discussing integration of services, most respondents referred to the linkage between family planning and STD services. One MOH official said, "Now we are integrating STDs into MCH to counsel and treat reproductive health. We want to give a reproductive health mentality to health workers." In some cases, integration refers to direct linkages between services. For example, midwives trained in postabortion care are also trained in postabortion family planning. A respondent from a U.S. technical assistance organization noted that family planning clinics are often separate from the emergency obstetric services. In this case, midwives and physicians delivering postabortion care provide referrals for family planning. Noting the need for service integration, the respondent said, "We are trying to put the family planning services in the emergency clinics too."

The Planned Parenthood Association of Ghana (PPAG), the local IPPF affiliate, acknowledged that it does not offer all reproductive health services and that the services are not completely integrated. "We use a holistic look at women's reproductive health problems. We are doing a bit in our clinics... We

haven't been able to do much [with STDs]. Counseling, but no service provision. We are not able to do tests, so we refer to government hospitals... We don't have the money to equip [our clinics with everything." PPAG is working with a psychology professor to provide staff with training in counseling skills.

Youth and men are priority groups in Ghana. Many organizations, including NGOs and religious groups and churches, have established youth centers and youth programs that train adolescents and offer reproductive health counseling and education. There was widespread agreement that the gap between knowledge and practice in family planning and other reproductive health services—among both women and men—stems from male attitudes. In fact, several respondents pointed to male education programs and services that have be initiated by several organizations, including the PPAG. According to a respondent from PPAG, "The male aspect is a post-ICPD issue. We are interested in males more—the forgotten 50 percent are brought into the action."

Ghana is decentralizing its health system. As one government official noted, "There is new change on the ground... So we need to convince the district assembly that health is important to allocate resources for it. We need to really lobby them on why health is important because there are so many other causes." One respondent from a U.S. technical assistance organization explained, "In order to get more money to health, the MOH needs to convince the district assembly to allocate more money to health. They have to defend the budgets at the district level."

To increase awareness at the subnational level, the NPC has begun to establish national, regional, and district coalitions and networks that address various population and reproductive health issues. One network member noted, "We briefed the district assembly [in one district] so far. They have ideas of teen pregnancy as a problem, but they hadn't noticed they need to take action." An MOH official in the AIDS Control Program explained, "The role of program officers at the national level will be advocacy at the regional and district level to ensure adequate funding for HIV/AIDS/STD activities." NGOs also work with the districts to "make sure the issues are in their development plans."

Senegal. Respondents in Senegal said that the *Program of Priority Actions and Investments in Population, 1997–2001* is meant to shift activities from a project approach to a programmatic approach. By fitting all activities into the context of an overall program instead of viewing them in isolation, the government hopes to develop greater coherence in activities and improved coordination among donors. However, not all levels of the health structure provide the full minimum package of services outlined by the MSAS. A representative of a regional council mentioned that many of the health posts in the region had no staff trained in family planning.

In 1991, Senegal adopted the Bamako Initiative, which has further advanced community participation through locally elected health committees. A major strategy of the Bamako Initiative is the generation of funds at the community level to cover local recurrent costs, including the cost of essential drugs. The Bamako Initiative also emphasizes the importance of community mobilization for the management of health services. To date, however, respondents reported that the health committees have limited themselves to financial management and have had little involvement in promoting health services. Some projects are now working to encourage health committees to assume a larger role.

NGOs in Senegal are playing an increasingly important role in the implementation of reproductive health programs. Large nationwide NGOs, such as the Association pour le Bien Etre Familial (ASBEF, the IPPF affiliate) and Santé et Famille (SANFAM), provide a small proportion of overall family planning and reproductive health services, but respondents noted that the large NGOs set the standard for quality and contribute technical expertise to program implementation. Small community NGOs are a significant factor at the grassroots level, particularly in work with AIDS and female genital mutilation. Important,

too, are community organizations such as the *groupements feminins* (women's groups) that organized originally for political purposes but provide a structure with which development projects can work. For example, the Ministry of Women, Children, and the Family (MFEF) has involved a network of 500 women's groups in carrying out IEC in reproductive health. Such a network is especially important given that the MSAS has trained people in IEC only as far down as the district level while nurses in health posts do not have either the time or skills to engage in IEC.

In the public sector, MCH services are integrated to the extent that all services are provided by the same person in most health posts—but on different days. Family planning is further isolated from other reproductive health services in that it is often offered in a separate building. A respondent from a U.S. technical assistance organization reported that steps have been taken to incorporate STD treatment into MCH services. Specifically, syndromic algorithms have been developed and health personnel trained in their use, but the algorithms have not yet been incorporated into the MSAS flow chart, which is what health care providers refer to in practice. Furthermore, the respondent said that some of the staff is resistant to addressing STDs. UNFPA is supporting the MSAS in the integration of services by establishing pilot health centers that offer integrated reproductive health services in each of Senegal's 10 regions. Staff has been trained in reproductive health and clinics have been renovated to enable provision of integrated reproductive health services; this effort is now entering its final stage of reorganizing patient flow. At one health center, the doctor reported, "We are tending toward integration." In his clinic, all services were available on all days, except for vaccinations, which were available only on a specific day.

In addition to these preliminary efforts at integration, the Ministry for Youth and several NGOs have started some pilot projects that offer reproductive health IEC and services to youth. Some new projects specifically address men, such as a project run by ASBEF that provides family planning information to men in the police and military. Preliminary projects are also underway in areas of reproductive health that previously were largely neglected, such as postabortion care and female genital mutilation.

Jamaica. In Jamaica, few program changes have occurred as a result of the 1994 ICPD. Despite the existence of documents such as the *National Plan of Action for Population and Development (1995–2015)*, Jamaica has not developed explicit operational plans to implement reproductive health. A donor representative noted, "I haven't seen any changes in programs." While all the elements of reproductive health are available in Jamaica, services are not all generally available in one place. Some clients might have to travel for some services (e.g., STD treatment, cancer screening, and infertility). The most well-developed elements of reproductive health are family planning, MCH, and STD/HIV/AIDS. Family planning and MCH services are accessible to most Jamaican women, although adolescents and men are not well served through the family planning program.

Family planning is integrated into MCH services. Said one government representative, "Integration takes place at the service delivery level. Maybe family planning and MCH services are offered on different days, but the staff is the same. Clients need to know which days to get which services." But, according to a government representative, "Twenty-five years after integration of family planning and MCH, some service providers still think family planning is an add-on." Some discussion has focused on integrating STD/HIV services with family planning services in the public sector. According to a government representative, "Realistically, we should start with the big ones—then it will be easier to integrate other reproductive health elements." Still, integration of services raises concern about turf issues. One government representative mentioned, "Institutions are worried about turf and keeping their institutions in place. Can you integrate without making structural changes? Do you change management structures?"

Currently, according to a government representative, "The Epidemiology Unit in the MOH works vertically with the MCH clinics on STD and HIV activities… Their approach has been that they need the Epidemiology Unit to overcome the MOH bureaucracy." Despite some linkages between family planning

and STD/HIV services, the linkages have proved inconvenient for clients. According to a government representative, "If a client has a vaginal discharge, she may be told that the STD clinic is on Wednesday. But it may be a yeast infection." With funding from the Pan American Health Organization (PAHO), the North-east region of Jamaica is a pilot area for the integration of family planning and STD/HIV services (but not administration of the activities within the MOH). Many challenges to the integration of services remain, including decisions on the scope of integration (e.g., administrative and service integration, at what levels of the service delivery system, and complete integration versus linkages).

FAMPLAN, Jamaica's IPPF affiliate, participated in a program between 1993 and 1996 to integrate STD into family planning services. As a result of the project, "The typical counseling session had evolved from mainly informational into a real exchange between counselor and client that explored the client's needs within a sexual and reproductive health context" (Becker and Leitman, 1997:3). The key to project success was extensive and participatory training for providers, many of whom needed to break down their own biases against STD clients. The program, which resulted in increased condom use, did not take more time on the part of workers, who had feared an increased workload.

Adolescents, a priority group in Jamaica, have historically not been well served by the health system. According to an NGO representative, "Traditionally, adolescents have fallen in mid-air in the health system… The [1995] quality of care study showed that providers are more reluctant to give contraceptives to girls than boys." A private provider commented, "I see pregnant girls age 13 to 16. Some say they haven't heard of family planning or that they were on the pill but didn't remember to take it or they were experimenting. None are happy to be pregnant. Thank goodness we have a good branch of the Women's Center [which serves pregnant teens] here. We need to provide adolescents with access to accurate information and services." An NGO representative in Jamaica said, "We need to start earlier with adolescents. Then it will take a decade to see the change. That is the only hope."

Another group targeted for reproductive health services is men. How much attention men's reproductive health will receive in the coming years has yet to be determined. According to a government representative from Jamaica, "We need to decide the goals and objectives and then we can design programs for men."

Peru. CONAPO, the National Population Council, existed between 1982 and 1996 to coordinate and plan population activities, including family planning. In 1996, President Fujimori announced the creation of the Ministry for the Promotion of Women and Human Development (PROMUDEH) partly in response to a commitment he made at the 1995 Fourth World Conference on Women. PROMUDEH took over the functions of CONAPO, although in a much diminished form, as well as some of the functions related to women and reproductive health previously under the purview of other government ministries.

Five years ago, Peru's programs were vertical. Today, most reproductive health services are provided under the umbrella of the Social Programs Department within MINSA. A MINSA respondent remarked that the agency should be called the Department of Reproductive Health, but names and structures are slower to change than the content of programs. Four programs fall under the department: family planning, maternal and perinatal health, school and adolescent health, and control of cancer of the reproductive tract. A MINSA respondent commented that the programs are coordinated, but that integration is difficult. Each program has its own system of supervision, its own IEC program, and so forth. Family planning is by far the largest of the programs. The program for cancer of the reproductive tract was an empty title until recently, but it has now received some funding and is developing guidelines and programs. Respondents said that family planning is such a high priority that it is not integrated with other reproductive health programs but is instead administered vertically. The Program for the Control of STDs and AIDS (PROCETSS) falls under a different department. A representative of PROCETSS reported that its coordination with the reproductive health program is "distant."

MINSA does not have a strategy to integrate reproductive health services, although MINSA officials are aware of the concept of integration and are making some efforts to strengthen linkages between various service components. For example, MINSA is promoting postpartum family planning services, and cancer screening and diagnosis and treatment of STDs have been included in the new family planning guidelines. PROCETSS has been training personnel responsible for family planning and prenatal care in the syndromic diagnosis of STDs. At the health-post level, one donor respondent said that services could be considered integrated because one person is providing all services. Another respondent commented, however, that because family planning is such a high priority, other elements of reproductive health do not receive adequate attention. A MINSA representative said that there are still separate rooms for different services. "When you walk into the center you won't see a sign that says 'Reproductive Health.'" Although practices are more integrated than in the past, representatives from local NGOs in one region reported that services remain separate. They noted, for example, a separate room for prenatal care and pointed out that personnel must ask patients such a long list of questions related to prenatal care that there is no time to address other issues.

Community-level NGOs working with women have a much broader concept of integration in Peru (as in other countries) than do national organizations or government institutions. Representatives from these NGOs pointed out that health is just one of the problems women face and that "it would be interesting to view their problems in a more integrated fashion." Health problems are often related to other issues; for example, a woman may be experiencing problems with her pregnancy because she has to perform heavy labor as a consequence of either her economic situation or her relationship with her husband. Unfortunately, health personnel do not have the time or skills to address the full array of related issues. In many cases, health personnel are working closely with NGOs to refer women to organizations that can help them.

7. Financial Resources for Reproductive Health

Countries need sufficient financial resources to implement expanded reproductive health programs. In each of the eight countries, funding for reproductive health comes from a combination of government, donor, and domestic private and voluntary sector funding. In addition, in many countries users pay for some services obtained through the public and private sectors. The proportion of funding from each source differs by country. Some respondents noted that funding levels are increasing, although it was difficult to get information on exact levels of funding in some countries. Nonetheless, with the exception of Bangladesh, funding constraints plague all countries. Thus, all eight countries are seeking ways to improve the sustainability of their reproductive health programs.

Bangladesh. During the past few years, funding levels for reproductive health in Bangladesh have been increasing in real terms; however, a government respondent stated, "Resource allocation does not yet reflect the priority placed on reproductive health in Bangladesh. Population is the biggest problem, but education receives the most money, followed by health and then family planning." Respondents agreed unanimously that the program is overly dependent on donor funds. Approximately 63 percent of the total development budget is donor-funded. Donor funding is decreasing, however, at the same time that demand for services is expected to double in the next 10 to 12 years. Still, according to a donor representative, "Frankly, I don't see financial sustainability as a problem—the donors and their money will always be here."

To increase the financial sustainability of the reproductive health program, the MOHFW is planning to introduce user fees for public sector services. The initial goal is to charge a small participatory amount,

but not to attempt full cost recovery. Once user fees have been introduced in all public sector clinics nationwide, the fees will gradually increase to recover a larger proportion of costs.

India. In real terms, recurrent expenditures for health and family welfare declined from 1991 to 1994. To implement the reproductive health approach fully, India will have to make a strong financial commitment to increasing program funding. With structural adjustment measures underway, it seems unlikely that the Indian government—with its mixed support for reproductive health—will be able to meet its financing challenge on its own. Donors are increasing their aid to the program, and some experts expect donor funds to continue to increase and play a larger role in the program in the future.

India's program allows for limited cost recovery. One respondent said, "PHCs [primary health centers] are not encouraging user fees. At the district and subdistrict levels, we are trying to encourage charging a user fee… People respect things they pay for. Also, there is an incentive for the ANM [auxiliary nurse midwife] as she keeps a nominal amount of 10 *paise* for every condom." The Social Marketing Corporation charges fees for oral contraceptives and condoms. Some NGOs have instituted fees, and private commercial providers charge for curative services, such as STD treatment. However, because such a large percentage of the population lives below the poverty line, respondents said it is likely that the government—or donors—will have to continue to play a major role in funding the health and family welfare program.

Nepal. In 1994, Nepal's health sector received 3.8 percent of the government's total expenditures, or only 0.7 percent of the gross domestic product. Donor support accounts for nearly half of the total health budget and covers 58 percent of primary health care activities. Most respondents said that Nepal lacks the necessary resources to embark on an expansion of reproductive health services. A donor representative stated, "It is the donors who are the biggest defaulters and have not increased their resources for reproductive health." An NGO representative commented, "Many more resources are needed. Many donors are cutting back their programs or at least not increasing the resources. Cost recovery efforts are small even within the NGO sector."

Jordan. In Jordan, most of the funding for family planning and reproductive health is allocated by the government through the MOHHC, whose budget is 5.2 percent of the total government budget (Almasarweh, 1997). A respondent from a U.S. technical assistance organization commented, "Funding levels are not bad now, but in the future they may be different with the new implementation plan [for the *National Population Strategy*]." Offering the broader reproductive health services envisioned by Cairo will be expensive. One government official noted that lack of implementation of population policy is partly attributable to the limited amount of donor funding.

Ghana. It was difficult to get a response about funding for reproductive health in Ghana, although one government respondent said, "The government of Ghana does spend a large bulk on health." While one NPC staff member noted that the government has started to fund more population activities and that Ghana is not currently overly dependent on donors, other respondents concluded otherwise. Several respondents commented that the role donors and NGOs play is crucial in providing information and services to underserved populations, especially at the district level. One donor and one government respondent thought that there was a particularly high degree of external assistance and dependence on donor funds. Respondents noted that resources are insufficient to implement a comprehensive reproductive health program that would include expanded access to services throughout the country.

Senegal. Funding for health in general is increasing. The government has committed to increasing the percentage of its budget devoted to health by 0.5 percent per year to a total of 9 percent in the year 2000. A government official commented that the government does not devote much of its resources to

reproductive health. The official's response might have been prompted by the fact that the government uses its resources to fund areas of less interest to donors. All respondents agreed that donors are a huge financial presence in Senegal. One MSAS respondent said that foreign aid covers as much as 90 percent of reproductive health activities, as opposed to health activities in general, which receive a greater proportion of government funds. An NGO representative commented, "Everything is paid for by the donors."

Cost recovery, a significant source of funds for the operation of health districts, is also increasing. Through the Bamako Initiative, community health committees set nominal fees for various medications and services. The funds generated under the initiative are then used to buy more medications, pay personnel, and cover the general operational budget of health centers and health posts. Respondents believe that the trend is toward increased cost recovery, which is critical for sustainability. Some expressed concern, however, that prices are widely variable across communities and in some poorer regions may be out of reach for local populations. One respondent commented that for family planning in particular, the program is still trying to spark demand, and contraceptive prices that are too high may pose a barrier to access.

Jamaica. In 1994–1995, the MOH received 5.8 percent of the national budget compared with 6.7 percent in 1989–1990 (Wright, Blumberg, and McKenzie, 1995). Family planning has no special earmark in the national health budget, and the budget for primary health care does not provide extra funding for reproductive health activities. As donors reduce their funding in Jamaica, the government is picking up some of the expenses. For example, the government is now paying for contraceptives—an expense that USAID covered until recently. Under Jamaica's health sector reform, it is not clear what will happen with the health budget.

All respondents spoke about the need to increase the financial sustainability of reproductive health services. The government has worked to shift family planning users to the private sector; still, the MOH is committed to providing free services to at least 40 percent of the population as a safety net for the poor. The MOH has implemented a successful cost recovery program for hospitals but has no plans to extend it to primary health care. A proposed national insurance scheme would apply only to hospital coverage. One NGO representative suggested that family planning and reproductive health should be beneficiaries of the lottery. FAMPLAN, which recovers 50 to 60 percent of its costs in two clinics, is also seeking ways to improve its financial sustainability. Most respondents noted that funding for reproductive health activities was a constraint to expanding programs. "We could do more if we had more funding," whether for training providers, extending services to youth and men, expanding access to more elements of reproductive health, or developing and disseminating more materials. A government representative tried to be optimistic by saying, "If people buy into reproductive health, the funding should come."

Peru. In recent years, the government has dramatically increased the levels of funding it commits to reproductive health, particularly family planning. A respondent from a U.S. technical assistance organization reported that in 1996 the government budgeted US$8 million specifically for family planning, and another US$160 million for its Basic Health for All program, which includes many elements related to reproductive health. Respondents reported that the increases are most pronounced in family planning, but maternal health is also beginning to receive increased government support, particularly with the new "Emergency Plan for the Reduction of Maternal Mortality." Similarly, AIDS, STDs, and family life education are receiving high levels of government support. With the increased commitment of the government to reproductive health programs, donors are playing a progressively marginal role. One donor estimated that donors provide 10 to 15 percent of the overall MINSA budget, although the percentage for reproductive health is much higher. The same respondent described the current role of donors as to "…help the government extend services to places where there are none, and to work with MINSA in a cooperative way to improve the quality and range of services."

The public sector has recently eliminated fees for family planning services and the treatment of STDs and is considering a proposal to provide free childbirth services. While respondents acknowledged that free services would increase access to family planning and delivery services, many raised concerns about the sustainability of the practice. "There is a need to develop criteria for what services the state can offer free to the whole population and which to offer to only low-income populations," according to a MINSA respondent.

Several respondents cited limited financial resources as a constraint not on family planning but rather on other components of reproductive health. For example, one respondent mentioned that MINSA has established a domestic violence prevention and treatment program but has no funds to implement it. Clinics are supposed to provide free treatment for domestic violence but frequently do not have the resources to cover the expense and therefore are forced to charge. In addition, the high cost of some components of reproductive health limits the availability of services, such as for treatment of gynecological cancer and perinatal transmission of HIV.

8. Moving from Policies to Programs

Cairo provided an international endorsement for addressing the sensitive issues of reproductive rights and sexuality, providing services to adolescents, and helping individuals and couples fulfill their reproductive health and reproductive intentions, among other things. Cairo also provided the framework for adopting a client-centered, holistic approach to reproductive health services. While the ICPD did not provide a blueprint for implementing the *Programme of Action,* an NPC staff member from Ghana said, "We live in a global world. Our programs are also in ICPD. So Ghana is not working alone. It gives even more credit to what we are developing... It makes acceptance of our programs easier." As shown by the eight case studies, countries are tailoring their approaches to the formulation of reproductive health policies and programs according to their own circumstances.

At the national level, the eight countries have made considerable progress in the area of policy development. Some countries have formulated reproductive health policies while others have produced strategic plans to link the elements of reproductive health. Many respondents echoed the sentiment that countries have established sound policies but, particularly in the areas of integration and decentralization, have experienced less success. Several major challenges face countries as they move from policy formulation to program implementation.

Improving Knowledge and Support among Stakeholders

There has been much discussion about reproductive health in all eight countries. Simply adopting policies based on the 1994 ICPD definition, however, does not ensure that policymakers, program managers, and health care staff will understand what reproductive health means in the lives of clients and therefore what services should be provided to clients.

Bangladesh. Since the ICPD, Bangladesh has conducted several workshops and seminars while policymakers are generally aware of, interested in, and knowledgeable of reproductive health but may not understand all of its elements. Some policymakers, however, have a narrow understanding of reproductive health and view it as a new name for family planning. Only a limited number of MOHFW personnel at all levels have an integrated view of reproductive health or even adequate knowledge of population issues. Service providers are not well trained in the concept of reproductive health. The

literate, urban population is knowledgeable about the need for reproductive health services and the program; in rural areas, however, only the elite with access to media are knowledgeable. The poor, rural, and illiterate population—which is the group that could realize the greatest benefit from reproductive health services—is not aware of reproductive health. A researcher said, "Rural women understand their own needs but are not familiar with the reproductive health elements. There is no concept of preventive care among rural women, and they seek treatment only when there is a problem. If we could understand how people think, we could more effectively target our message."

India. While the respondents interviewed in India were knowledgeable about reproductive health, an NGO representative noted, "The reproductive health concept is not well understood, although the policies on paper are good." Another stated, "India still has a long way to go at the state level. A lot of advocacy for reproductive health policies and programs is still needed." One respondent said, "The demographic target rationale is too deeply steeped in individuals... the old gang still opposes new directions. To them, choice is not important. They are concerned with decreasing numbers. The mindset of doctors and program people has not changed. There is no point in trying to change how the ANM works when other people in the program are still thinking quantity. The concept of reproductive health in India is still perceived in a very narrow sense. The program people interpret reproductive health as another word for sterilization." A respondent from a U.S. technical assistance organization agreed. "We need to carry out a major advocacy campaign if we want this paradigm shift to happen. To 'unlearn' demographic orientation is more difficult. The major policy planners in India are demographers… First, they have to believe differently. Operationalization will come later."

The vast majority of Indians have little knowledge about the new reproductive health approach. While knowledge of contraceptive methods is high, knowledge of reproductive health is more limited. For example, although abortion has been legal in India for more than 25 years, many women are not aware of its availability. As a result, most abortions are performed under unsafe conditions. Most women still deliver at home and many do not seek prenatal care during the first trimester. Several studies that interviewed community women about symptoms of RTIs revealed that women do have knowledge of abnormal and normal functioning of their reproductive system; however, they have little knowledge of RTI interventions. Providers have neither received training in nor practiced standardized detection and treatment protocols. The population has little knowledge about AIDS and how it is spread and prevented. Among the population without access to mass media channels, the RCH program will conduct IEC activities to build local capacity for health education and counseling on family planning, safe motherhood, essential obstetric care, and RTIs/STDs. The program will also fund media activities and audience research to improve IEC in the mass media as a means of increasing reproductive health knowledge.

Nepal. Since the ICPD, the MOH, NGOs, and the donor community have conducted several workshops and seminars, but frequent political changes have limited advocacy efforts aimed at building support among policymakers. A bill on decriminalizing abortion was prepared several months ago and has been discussed in Parliament, but no resolution is evident. Meanwhile, many respondents stated that policymakers are ambivalent about reproductive health. Nepal needs to undertake a much more concerted effort to raise awareness and build consensus around reproductive health, especially in relation to adolescent health and abortion. An MOH official said, "There is awareness for HIV/AIDS; however, with a frequently changing government, we need to keep reeducating them."

The MOH officially adopted the *Reproductive Health Strategy* in February 1998 but has made no effort to disseminate it to other stakeholders and health care providers. In response, one donor representative said, "No doctor in the district could define reproductive health." Service providers mentioned that they had received neither notification of any change in program strategy nor any training in reproductive health. Another MOH respondent complained, "We have a big problem with new concepts. New names are

brought in, for example, we first used the term venereal disease, then sexually transmitted diseases, followed by sexually transmitted infections, and now reproductive tract infections. Same thing with reproductive health. First it was known as MCH, then family health, and now reproductive health. Half the money just goes in disseminating the new concepts and counseling health workers." Furthermore, Nepal has made little or no effort to involve other ministries, such as the Ministry of Youth and Sport, Ministry of Women and Child Welfare, or the Ministry of Education, in discussions or activities on reproductive health.

Jordan. Some respondents pointed to a need to increase public awareness about population and reproductive health issues, notably convincing men of the benefits of family planning and educating women on their legal rights. The NPC, the JAFPP, and donors have supported a number of activities to increase knowledge and support for population activities in general and to increase awareness of reproductive health in particular. Jordan has made progress in working with religious leaders, policymakers, and the public; however, much remains to be done. Awareness-raising activities need to continue to be targeted at high-level policymakers. In addition, greater efforts need to be made at all levels of the MOHHC bureaucracy, including service providers, to emphasize the benefits of a reproductive health approach. Awareness-raising activities should also be increased for private sector providers, many of whom are still skeptical of family planning and know little about reproductive health. One MOHHC respondent noted, "We were not involved in the Cairo conference. We know about it though. The term 'reproductive health' is recently introduced. We changed our terminology from 'family planning' to 'reproductive health'... In practicality, we still deliver MCH/family planning."

Ghana. One respondent from a U.S. technical assistance organization characterized the public's view of reproductive health by commenting, "There is not really an objection to reproductive health, but a lack of awareness. People are not really conservative. If you talk to them, they have the wrong impression of family planning/reproductive health because earlier the talk was of only family planning, and reproductive health is new since 1994. A lot of people haven't got this in their minds yet. When we explain, all people say this [reproductive health] is something we should all address." Several respondents noted that parliamentarians, including those in the population caucus, are not informed. A respondent who attended the post-ICPD parliamentarians' conference said, "Parliamentarians' knowledge is not very good—locally or internationally. They do not go in-depth on any issue... They are just not thinking about it [reproductive health]."

Several respondents also noted that many public and private sector providers do not know the term reproductive health, although health workers understand the separate elements. An MOH official explained, "People know one reproductive health area by one. The term itself is difficult and hard to understand by health workers." A respondent from a U.S. technical assistance organization added, "These international ideas come along and they want to categorize everything and push single ideas... A health post may be baffled if you ask about reproductive health if they have not read the guidelines [and thus have not seen the term 'reproductive health']. But if you ask about each element, then they will say they offer them all." The MOH is trying to educate all providers as it disseminates the *Reproductive Health Service Policy and Standards*. A local reproductive health assessment by a project carried out by a U.S. technical assistance organization found almost universal awareness among the public of AIDS and STDs in addition to family planning. The project's representative said, "This high level of awareness is good. It's great!" Others noted that although knowledge of AIDS is widespread, people do not believe it is "real" and that it could affect them or people they know.

Senegal. Many respondents stressed that political leaders in Senegal have been extremely cautious in their support of reproductive health programs and that politicians will act in favor of reproductive health only when they see that it is what the people demand and therefore poses no political risks. While respondents agreed that the concept is gradually becoming clearer, some confusion persists. As one

respondent from a U.S. technical assistance organization commented, "The spirit of reproductive health has been adopted, but it has not been totally absorbed." A government respondent emphasized the need for further clarification: "How can we develop programs if the concept is unclear?" Several respondents expressed the hope that the new *Program of Priority Actions and Investments in Population, 1997–2001* would clarify the concept. An NGO respondent said, "The concept of reproductive health has not been popularized. It is discussed only among intellectuals." One government respondent inquired if reproductive health is supposed to have any programmatic implications, suggesting that he perceived the concept to relate to a change in rhetoric, but with limited impact on actual programs. A doctor and a midwife in regions outside Dakar had both heard of reproductive health but were not entirely clear about its meaning. The doctor said he had not entirely grasped the concept. "It is a new term, but we have been working in family planning, STDs and AIDS, and maternal health for a long time. I am not clear what it means in practice. Maybe it means we will be getting more money?"

With decentralization, the support of locally elected leaders for reproductive health programs and policies has become extremely important. While local leaders are particularly heterogeneous, it can generally be assumed that most of them know little about reproductive health. It remains to be seen what impact their lack of knowledge will have on the implementation of reproductive health programs. Some donor respondents and respondents from U.S. technical assistance organizations, discouraged by a perceived lack of commitment at the central level, are more optimistic about the effectiveness of working at the local level. Respondents stressed the importance of working with community NGOs that have close ties to the population and using outreach workers to increase the awareness of people at the community level.

Jamaica. Few people in Jamaica can define the term reproductive health, although program planners tend to be more knowledgeable than either policymakers or providers. A representative from the private sector related, "I asked [a policymaker] to define reproductive health and that person spoke very broadly about it involving breastfeeding and women's health." According to an MOH staff member, "When you say the words, different things come to people's minds. Reproductive health means the womb to the tomb. A holistic approach to women, men, and adolescents." A government representative said, "Reproductive health isn't only genital organs, but is also mental and social."

One government representative said, "Those most familiar with reproductive health aren't implementers. Those who went to all the conferences don't have time to put it all together… A lot of material on reproductive health exists, but people aren't going to read it." According to a donor representative, "When you talk to people here, it's still family planning even though people talk about reproductive health." A government representative said, "There will be no change in staff and the clients will be the same so we need to figure out how to get providers to see an individual person with his or her reproductive health needs." Even though Jamaica lacks a systematic program to inform providers about reproductive health or to train them in it, an MOH staff member is optimistic that the staff understands the components of reproductive health. "To workers, reproductive health is a new concept. They probably wouldn't know how to define it, but they would know the individual elements." She added, "Some providers are starting to say reproductive health instead of family planning, especially doctors, midwives, and public health nurses."

IEC and advocacy activities for family planning and STD/AIDS have been strong over the years in Jamaica. Knowledge among providers and the public about these two components is high. Some respondents noted the need for a coordinated effort at informing providers and the public about reproductive health. A government respondent added that the IEC committees and departments in various agencies should work together to publicize reproductive health. "We need to link IEC activities so that we are all giving the same messages." Another government representative noted, "We need to sell reproductive health as important to people's lives." Many respondents noted that reproductive health should be addressed in the context of people's lives, particularly in relation to poverty alleviation. An

NGO representative noted, "Reproductive health is nice, but we need poverty eradication… If people have to choose between food and condoms, they just hope they don't get pregnant." A government representative agreed, "We have made great strides, but we will never adequately deal with women's reproductive health until we eradicate poverty, improve women's education, and make them [women] autonomous."

Peru. In Peru, the concept of reproductive health was not new as a result of Cairo. A MINSA respondent said that as long as 10 years ago MINSA was working in reproductive health through a small PAHO project. Over time, the concept has been refined, more broadly understood, and more consistently applied. Nonetheless, the ICPD was an impetus to this process and had a major impact on the rhetoric surrounding the concept of reproductive health. The term "reproductive health" is now incorporated into programs, projects, publications, workshops, and speeches with far greater consistency than just a few years ago.

Although the concept of reproductive health is widely accepted, quality of care and a client orientation have received less attention. At the time of the interviews, the government's promotion of sterilization was particularly controversial. In response to mounting criticism, MINSA instituted safeguards beginning in February 1998 to ensure that women would be able to make a free and informed choice concerning contraceptive methods.

A few respondents said that REPROSALUD, a USAID-funded project being implemented by a women's NGO, is an important effort to allow rural women the opportunity to define their own reproductive health needs. When asked about women's opportunities to participate in reproductive health programs, a representative of REPROSALUD said, "It is not a question of women fitting into programs, it is a question of women taking care of their own reproductive health. Programs need to adapt to their culture."

Planning for Integration and Decentralized Services

The Cairo mandate, if completely implemented through an integrated reproductive health approach, requires careful planning and coordination among a number of government and nongovernmental agencies. In some cases, changes in institutional arrangements are necessary. In some countries, lack of planning for program implementation—including planning for integrated or decentralized services—has hampered the development and delivery of reproductive health programs. In addition, institutional constraints and coordination problems among organizations have impeded progress in implementing reproductive health activities. Disagreements over jurisdiction and responsibility between central and local levels or between different ministries or departments within ministries have limited progress in a number of countries. Finally, while countries assume that Cairo called for integrated reproductive health services, many nations have not fully considered the complexity of integration, which requires careful planning from the national ministry down to the smallest health post (see Hardee and Yount, 1995).

Clearly, policymakers and program planners have not fully appreciated the differences between administrative and service integration or the requirements for successfully implementing either type of integration. Several countries have been grappling with the complexities of integration, which, according to WHO, is not a panacea (WHO, 1996). Integrating already weak vertical structures does not necessarily improve the quality of those services. In fact, it may be easier to develop referral systems and other linkages between the elements of reproductive health than to integrate services fully.

Although they do not tend to reach large percentages of women and men of reproductive age, NGOs have been the most flexible and innovative of all institutions in their attempts to reorient their programs to reproductive health. Public sector programs can draw important lessons from the NGOs' experiences.

Bangladesh. Respondents commented almost unanimously that the bifurcation of the two directorates in the MOHFW must be addressed. The government is aware of the problem. The artificial separation of the directorates of health and family planning is counter to integration, yet the political will to integrate them is absent. A high-level committee consisting of government, NGO, and private sector representatives was formed at the request of the World Bank to study the issue. A donor stated that there is a "need for organization and management reform within the MOHFW, and if the two directorates don't get together, then the essential services package won't happen."

Other institutional constraints also impede reproductive health policies and programs. Groups working within the health sector tend to protect their own interests. Providers are unionized; therefore, their jobs are secure regardless of whether they perform the roles for which they were originally hired. Regulations that place limits on the types of services to be performed by paraprofessionals protect the interests of physicians. Infighting often characterizes the relationships between medical and nonmedical personnel. Finally, the structure of MOHFW programs is designed for rural areas, although the annual rate of population growth in these areas is 2 percent compared with 6 percent in urban areas and 13 percent in the slums as a result of in-migration. No public sector preventive health care infrastructure is in place in urban areas, and the government strategy is to rely on NGOs and the private sector for urban services (MOHFW, 1997). Some donors are working with NGOs to strengthen services in urban areas.

India. Amendments to the Indian constitution passed in 1993 shifted control of the health and family welfare program to local governments: rural *panchayats* and urban *nagarpalikas.* Yet, the central government has continued to control the program. In the process of decentralizing, the states have not yet become fully empowered to direct and manage the program. One donor representative stated, "Serious communication gaps exist between the center and the states. Policies are mainly formulated at the center." The poor planning and implementation of the target-free approach have led to declines in family planning use in many states. One donor representative remarked, "We need a narrow set of priority interventions. The demographic impact has been pushed to the background. If reproductive health services are provided in a comprehensive manner, eventually population stabilization will happen. However, if not, then it could pose a serious problem. Family planning is the most important intervention to time and space births."

Various institutional obstacles hamper the progress of fully implementing the reproductive health approach. A lack of continuity in governments, rapid changes of bureaucrats in leadership positions within the health and family welfare program, and lack of political will in certain states have slowed implementation. Since the ICPD, the MOHFW has had four secretaries. A conservative medical establishment and some women's NGOs are opposed to both delegating tasks to other levels of providers and introducing methods that would greatly expand choice in spacing methods. Another issue is a lack of political will to work on AIDS. Several respondents cited problems in coordination of activities between NACO and the Family Welfare Division. Many service delivery NGOs have been offering integrated reproductive health services for some time, although their coverage is very limited. An Integrated Child Development Scheme that is staffed by an *anganwadi* worker charged with nutrition and growth-monitoring interventions also functions at the local level. There is one *anganwadi* for every 1,000 villagers while there is only one ANM for every 5,000 people. "If the *anganwadi* can join hands with the ANMs, service delivery in India can be revolutionized. There is reluctance on the part of both ministries," stated an Indian pediatrician. The earlier experience of the MOHFW and the Ministry of Information and Broadcasting in successfully increasing integration suggests another opportunity for implementing the reproductive health approach. Previously, the ministry reported to the MOHFW when

designing special campaigns on such topics as immunization, the girl-child, unequal access to food, and contraception; but now, according to one respondent, the two ministries do not communicate with each other.

Many of the respondents cited a lack of familiarity and experience with the new interventions as an obstacle to implementation. "We do not have any program experience of integrating family planning and STDs. Why do something on a large scale in which we have no program experience? Government is approaching the reproductive health issues very simplistically and trying to do things too fast. RTIs are a very difficult area to work in. There is no standardization of drugs. The syndromic approach has not been transferred to the grassroots level," stated an NGO representative. One respondent noted that an increased need for equipment and supplies would need to be satisfied before the new services could be offered. Of special concern was the difficulty of RTI screening. "Do we have the reagents to do the tests? Until some quick and simple tests become available, it may be very difficult; so many RTIs are asymptomatic," a donor official said.

Nepal. The reproductive health definition adopted by Nepal includes a comprehensive set of interventions recommended by the ICPD. The MOH, overwhelmed by the scope of the interventions, is keen to identify a set of realistic priorities that reflect Nepal's human resources situation, the existing health infrastructure, and resource constraints. The division responsible for providing reproductive health services—the Family Health Division—has equal status to other divisions, creating a lack of authority to guide the actions of other divisions, such as the Child Health Division and the NCASC. Furthermore, the *Second Long-Term Health Plan, 1997-2017,* developed by a different division of the MOH, does not reflect a reproductive health approach. An MOH official stated, "The concept of reproductive health is integrated but structurally and functionally it is not. In the development of the long-term health plan, no one from the Family Health Division was asked to participate." One respondent from a U.S. technical assistance organization mentioned, "Donors thought wrongly about integration. Integration at the lower level, but compartmentalization at the higher levels—it cannot work. It has to be integrated at the highest level to work." Another NGO respondent commented on the lack of integration not only within the MOH but also within the NGO community. He stated, "Many NGOs continue to retain their own focus."

Nepal has been advocating decentralization of health services for nearly three decades; however, attempts at implementation and community participation have been largely ineffective (MOH, 1997). Recently, with UNFPA support, the MOH has identified some pilot districts for "bottom-up planning."

Jordan. While respondents praised the achievements of the NPC, especially given its limited staff and resources, some noted that the NPC does not meet frequently enough and that coordination between the NPC and other organizations often does not reach deeper than the designated NPC member. Some respondents said that the NPC needs to improve its coordination efforts to implement the *National Population Strategy*. One of the greatest challenges facing the NPC is its work with the MOHHC. Some MOHHC respondents said that they believed the ministry should have complete control over the population policymaking process and over donor funds for project activities. One NGO representative suggested that the NPC could bring donors and local NGOs together to discuss their projects and coordinate efforts.

To meet the demand for reproductive health services and allocate resources efficiently, Jordan needs to rank order its reproductive health problems and develop well-conceived plans for implementation, including mechanisms for monitoring and evaluation. Thus far, policymakers and program managers have not worked out a consensus definition of integrated services. One NGO, the Family Health Group, is undertaking a reproductive health assessment in a lower income area of Amman. The goal is to develop a model for reproductive health interventions. According to the NGO representative, "People

don't know how to integrate. They are asking for a model. It is not just physical integration, but system integration."

Ghana. A number of respondents noted that Ghana's basic infrastructure for delivering reproductive health services is deficient. Poor access to services in rural areas is a notable problem. A government representative commented, "The program needs to massively get into rural Ghana... If we don't make an impact there, then I'm afraid we won't make an impact at all." Respondents also said that supervision and monitoring is weak. One MOH official admitted that central staff members do not have enough time to travel to the field to supervise.

With reproductive health not subsumed under one division in the MOH, one respondent from a U.S. technical assistance organization questioned the definition of integration. She asked if reproductive health service integration requires a new structure of service delivery and argued that while the MOH structure is not termed "reproductive health," it offers all the services with established referral systems. "The MOH already had integrated services before the ICPD. They were not labeled reproductive health, however. It is a hospital which gives all health care. If someone has cancer and can't be treated there, there is a referral system in place... What is integration? Does it have to be one person providing all?" One university respondent commented, "What to integrate at what level? Some kind of framework is in the reproductive health policy. But you need to look at what is available at each level [in terms of manpower, skills, supplies, and equipment] and they [the MOH] haven't done this." In addition, providers need to be educated in the meaning of reproductive health integration and the expectations of their functions as service providers. Another university professor said, "The understanding of integration is a problem. Each provider has his own idea." Respondents argued that simply adding more responsibilities to health workers is not what is meant by integration. One NGO representative noted, "For example, with nurses, there is so much work for them. They do not have time to sit down. One-on-one [counseling] is a problem. For women with marital problems or menopause, you need time to talk or visit women at home."

Senegal. Since the ICPD, Senegal has done much to raise awareness and develop programs, but those programs are just now ready to be implemented. So far, only a few pilot projects in reproductive health are underway in the field. As one respondent said, "We have a good plan, the challenge now is to carry it out." The plans dealing with reproductive health envision a number of coordination mechanisms, but the poor record of many of the existing coordinating bodies raises questions about the effectiveness of the mechanisms.

Many respondents stressed the positive role of NGOs as pioneers and noted that, compared to the government, they are less bureaucratic, more flexible, and closer to the people. Some MSAS officials commented that NGO coordination is a problem, however. A regional medical officer commented, "There is a need for coordination between actors, but the [MSAS] regional office has no power over them."

In 1996, the government passed legislation outlining a process of decentralization for nine sectors, including health. Unlike other sectors, the health sector was already decentralized in the sense that MSAS officers at the regional and district levels had developed plans and budgets responsive to specific local needs. Health officers, however, do not represent and are not directly accountable to the populations they serve; therefore, the transfer of authority to local councils is a significant step in giving communities direct control over their own health services.

Decentralization provides both opportunities and challenges for the development and implementation of reproductive health programs. Communities will be able to develop programs that are more responsive to their needs. Furthermore, many individuals and groups will have an opportunity to participate in the

program development process. A technical officer in one region stressed the positive impacts of decentralization. "Since decentralization, all actors have been mobilized." Conversely, problems arise because many locally elected leaders lack both planning skills and a technical understanding of the importance of preventive health in general and reproductive health in particular. Health officials, who are still responsible for contributing to national health goals, are concerned that locally elected leaders will choose to spend resources on activities that have high visibility but low impact or that they will divert funds from health programs to other sectors. As one government respondent said, "Politicians are caught up in the short term. They don't think medium to long term."

Whatever the problems and possibilities of decentralization, its effects are somewhat mitigated because locally elected leaders still do not control a large proportion of funds. Donors contribute large amounts of project money directly to the health regions, leading one regional health officer to comment, "Decentralization is not a reality in the field."

Jamaica. It is likely that family planning, MCH, and STD services will be integrated—at least to some extent—in the near future in Jamaica. Setting clear priorities and planning what services will be available at different levels of service delivery points and with oversight by which department or departments in the MOH will help ensure efficient implementation of reproductive health. According to a government representative, "We need to be systematic about the integration. For example, in policy, do we advocate dual method use? For services, is the set up okay to do private counseling? We need to strengthen STD case management to make the right diagnosis and the right treatment. We need to promote risk reduction through the right behavior. For training, do providers have the counseling training necessary? For monitoring and evaluation, are all the forms and checklists available to make sure all the steps are followed? For IEC, is it designed to speak to integrated aspects of reproductive health? Have we educated the public about what services they should expect and have the right to? Have referral services been strengthened? Should we have specialists in the primary health care clinics once a month to take referrals?" Another government representative agreed, "I'm not even sure if the monthly clinic form has any provision for capturing who the clinics are seeing for STDs and who they are referring (like for tubal ligation)." Other challenges to integrating reproductive health include ensuring adequate supplies of commodities and providing reproductive health materials for all levels of providers and clients.

Several respondents noted that improved coordination is a challenge for implementing reproductive health programs at both the policy and program levels. Institutional issues sometime affect working relationships between the NFPB and the MOH. One government representative noted, for example, that the MOH might not be willing to accept a reproductive health policy or program that was perceived to have been developed by the NFPB. Coordination between the central office of the MOH and the parishes also requires improvement. Said one government representative, "If something is developed by the MOH and disseminated to the parishes, then everyone will have the same idea and they will implement it." Representatives from the Association of Women's Organizations in Jamaica noted that the association could be better linked with the NFPB by helping to advocate for reproductive health in general or by using its channels to lobby for more staff or for getting clinics open.

Peru. In part because PROMUDEH recently took over certain responsibilities from other ministries, many respondents reported no clear division of roles between PROMUDEH and other ministries. In some areas, PROMUDEH overlaps with MINSA and the Ministry of Education; in other areas, no ministry has jurisdiction. Most respondents agreed that intersectoral coordination is limited. For example, one MINSA representative remarked that the Ministry of Education developed its sex education programs independently of MINSA. Another supported this view, saying that PROCETSS had no involvement in the development of the STDs/AIDS part of the Ministry of Education's sex education guide. Respondents who had been involved with the now-defunct CONAPO felt that its absence is a major disadvantage, in that no organization is able to coordinate between ministries. Multisectoral

coordination on population issues continues at the regional level, however. Six regions have formed regional population councils (COREPOs) that are still operational. A member of one COREPO said, "We continue to function even though CONAPO has been disbanded because the members of the COREPO find it useful."

At the time of the interviews for this study, a "Tripartite Table" had recently held meetings with representatives of NGOs, donors, and government institutions. The objective of the Tripartite Table, funded by UNFPA, is to follow through on the commitments made in Cairo. A women's organization took the initiative to form the group, but leadership will rotate among NGOs, universities, government, and international organizations.

Developing Human Resources

In most of the countries, respondents mentioned several challenges related to human resources, namely, staff shortages, a lack of trained providers (particularly female providers), and overloaded workers. In addition, updating curricula and service delivery guidelines to reflect a reproductive health approach and expanded services will require both time and resources.

Bangladesh. One respondent in Bangladesh said, "Cairo assumes that there is already a good service delivery system in place, but the system in Bangladesh has many problems. Without trained health personnel, they cannot effectively deliver reproductive health services to the people who need them." The process to educate and train health workers in reproductive health has started. Institutions that train workers will have to change their curricula to include the new focus on reproductive health and the essential services package. When the directorates of health and family planning are integrated, their separate training systems will need to be integrated as well. In addition to training and to ensure greater impact, health workers need support through the provision of logistics and supplies, supervision, monitoring, and evaluation. One researcher stated, "We have a good infrastructure in the government system, but the weakest part concerns management issues, including supervision and monitoring."

Another constraint is the poor quality of education received by workers in the health sector. One researcher noted, "Cairo assumes that every country has a strong clinical base, but Bangladesh is really starting at the beginning with so many of these interventions. Workers don't know how to handle RTIs. The whole medical education has deteriorated in recent years. About 20 years ago, they expanded the medical college system to put a medical college in each region. Physicians and nurses graduate with no clinical training. There is no natural cadre of people to do reproductive health. Family planning visitors have limited clinical skills and their training is terrible. However, in spite of this, some manage to be extremely effective, probably because they had a good mentor once they began delivering services. The MCH medical officer is not trained to do the clinical work. The district medical officer is supposed to supervise but is not technically competent. Bangladeshi women are very modest and want to receive services from other women, but women are not trained. In short, the quality of training and the lack of practical experience is the problem."

India. In India, staff turnover is high and many positions remain vacant for long periods. "One big constraint is related to manpower and the nonavailability of qualified individuals willing to work below the district level. India has very few staff nurses. The nurse/doctor ratio is very poor. We need to augment the number of nurses," explained an official of the MOHFW. Other respondents countered that the problem was not a lack of manpower. "Manpower is available. There are problems with filling positions in some areas, [but] it is more an issue of management and time management."

Several respondents feared that the ANM already had too many assigned responsibilities and believed that adding reproductive health would create an overly burdensome workload. "The reproductive and child health approach has added more workload for the health workers," commented a representative of a population organization. "An ANM is required to do an amazing number of tasks [more than 40 tasks]… She is supposed to do community work and now additional reproductive health work. How much is feasible for her to do?"

Nepal. In Nepal, partly due to topography, access to health services remains a major constraint. The 1991 *National Health Policy* laid out an ambitious plan to provide a subhealth post at every village development committee level (for a population of 4,000), a health post for every five village development committees, and a primary health care center for every electoral constituency (MOH, 1991). According to the MOH Department of Health Services (1997), over 80 percent of the target had been met; however, most existing health facilities lack basic amenities, such as water and latrines. Furthermore, a shortage of personnel continues to be a major barrier to access. An MOH official commented, "The manpower situation is very poor in Nepal. Although we now have a good system of health infrastructure, a big percentage of these facilities are unstaffed." Another respondent from the MOH commented, "We need to have community schemes for managing local health posts and staff. Staff should be recruited from the same area." A representative from an NGO reflected, "We need to provide a better incentive structure for staff to stay. There are security problems for young female health workers in some areas."

One MOH official stated that the new dimension of reproductive health has created the need for further refresher training. He commented, "Workers who were trained five years ago need to undergo refresher training. We need to change their mindset because a lot has happened since then." Another critical problem identified by many respondents was worker overload. Respondents felt that adding new components to the activities of the workers may reduce further the number of contacts a health worker may be able to make.

Jordan. Some respondents stated that Jordan needs to work with its service providers by either delivering continuing education and training in reproductive health and family planning or convincing providers of the benefits of family planning and reproductive health. A few respondents underscored the problem of the lack of female physicians, especially in rural areas.

Ghana. Health personnel in the public, NGO, and private sectors are not trained to identify and deliver reproductive health services, and the overall quality of care is not high. Although the *Reproductive Health Service Policy and Standards* lays out minimum standards for skills and training requirements by type of service provider, Ghana has yet to develop an overall strategy for training all workers in needed skills. One donor explained, "Reproductive health is comprehensive. No one can implement all those services in the developing world. You must do it incrementally. You must train health workers slowly. And whether they can grasp all of this is another question." With respect to quality of care, an NGO representative said, "I like to think quality of care is high with us [NGOs]... There is a need for all providers to get trained for quality of care. It is virtually lacking in all places."

Senegal. Several respondents said that Senegal's available infrastructure frequently goes unused because of a lack of staff. The personnel situation is not well managed; the MSAS does not keep careful track of either staff departures (resignations, deaths) or recruitment. In general, the number of health personnel (particularly nurses and midwives) in the public sector is decreasing each year. Furthermore, personnel are poorly distributed and disproportionately concentrated in Dakar.

One donor respondent commented that a disadvantage to integrating services is that personnel frequently fear that integrated services will add to their workload. However, one midwife whose clinic had begun providing integrated services reported that she did not experience an increased workload. The other

difficulty mentioned by the donor respondent is that training personnel to provide integrated services means that they must leave their work site to receive the training.

Jamaica. In the public sector, staffing shortages and staff turnover have been issues in Jamaica's primary health care centers. In addition, providers have not been trained in an integrated approach to reproductive health. All respondents agreed with a government representative's assessment that "there needs to be a critical mass of trained providers to reach the community with reproductive health." According to a government representative, however, "We need training for reproductive health, but donors don't want to fund more training."

It appears that the changes in training have not been systematic but rather have occurred primarily through meetings and continuing education. Notes one government representative, "Training on reproductive health is supposed to occur in the four health regions. Funding is a problem, so it has only occurred in the South-east region. Midwives and nurses have periodic updates, which include reproductive health. And it is discussed during staff meetings." An estimated 80 percent of nurse practitioners are trained in the syndromic approach to treating STDs. A government representative noted, "Community health aides are also trained at an appropriate level for their duties, but they complain they have too much work." Preservice training has not adopted a reproductive health focus. One NGO representative noted, "The School of Nursing…is aware of Cairo, but they think they are already doing it." A government representative said that adding to an existing training curriculum is not easy. "The MOH is asking for the curriculum in the midwifery school to be revised to include reproductive health… If reproductive health is added, something has to be taken out. The nursing council would have to decide."

Peru. A shortage of trained health personnel in Peru limits access to reproductive health services in many remote areas. The abandonment of many health posts in the 1980s and early 1990s in response to violence in much of the country exacerbated the problem of access. MINSA is attempting to address the issue through its Basic Health for All program, which pays health personnel a supplement to work in underserved areas. A program called CLAS, through which communities hire their health personnel directly, is another approach to addressing the lack of trained health personnel.

Because of limitations of time and skills, health personnel are frequently unable to provide high-quality integrated health care. They usually must attend many patients in one day and do not have time to discuss all of a patient's needs. "The nurse is required to be lawyer, psychologist, and social worker all in one, but she receives no training to play all of these roles," said an NGO representative. Another constraint is that health personnel do not command all the skills necessary to address women's broader reproductive health needs, particularly in matters such as domestic violence and services for youth. For example, one NGO respondent said that MINSA's School and Adolescent Health program is impressive on paper, but is not carried out "basically because the staff don't know how. They have a tremendous amount of enthusiasm and interest to work with youth, but they do not have the skills."

Improving Quality of Care

Another challenge in implementing reproductive health programs is maintaining, in most cases, improving the quality of care that clients receive. In most countries, the current level of quality of care in family planning and other individual components of reproductive health is low; integrating and expanding services only adds to the challenge of achieving a desired level of quality of care.

Bangladesh. Many clients in Bangladesh feel that the current family planning program does not adequately meet their needs. According to a study funded by USAID in 1995, a "majority of women protested about a number of shortcomings: irregular visits by fieldworkers and paramedics or the failure of these personnel to visit all potential clients (including newlyweds); closed facilities, unavailable doctors, and shortages of suitable contraceptives, especially clinical methods; demands to purchase ostensibly free contraceptives, medicine, and immunizations; brusque, inconsiderate treatment; and failure to answer questions or motivate clients or to provide them with counseling and follow-up services" (USAID, 1995). One respondent noted that service providers lack a "client focus" and deliver the services that the provider thinks the client needs—with little regard for client preferences. Consequently, many women report problems and dissatisfaction with their contraceptive method, thereby leading to a high level of method discontinuation.

Many respondents said that they received higher quality services from NGO clinics than from government clinics, and some stated that they preferred to patronize private providers. Nonetheless, the public sector continues to be the largest single provider of family planning and MCH services in Bangladesh. Improvements in the quality of public sector services will have the greatest impact on improving the reproductive health of the population. Small pilot programs have shown that improved quality of services results in increased levels of contraceptive use (POPTECH, 1995). Additional strategies under consideration for improving quality of care include upgrading monitoring and supervision, using pilot projects to illustrate that quality improvements increase client satisfaction, expanding the availability and range of contraceptive methods, and encouraging both medical and nonmedical staff to become involved in decision making, management, and the improvement of both their clinic and the services they deliver.

India. The quality of care in India's family planning services has been poor. Numerous studies have identified problems with respect to infection prevention, counseling, and follow-up care. A government official stated, "There are small things that can make a difference, such as a clean tray for delivery, heating arrangements for a newborn child, and basic cleanliness." India's essentially one-method program meant that female sterilization was the predominant means of contraception, with incentives for providers and clients and specific targets to be fulfilled; as a result, women had no real choice. Sterilization was often provided in camps that lacked time or equipment for proper infection prevention measures as well as time to counsel clients and that provided no follow-up in the case of complications. Male methods were neither readily available nor promoted. The clinic and hospital infrastructure needs extensive renovation and upgrading. Facilities offer clients little privacy. Despite the introduction of the new "target-free approach," conditions in India generally have yet to change.

Ghana. Several respondents pointed out the difficulties of counseling—space for private conversations, time for health workers to talk to clients, or the availability of appropriately trained workers. One representative of a U.S. technical assistance organization stated, "What is needed is counseling skills. Real counseling, not just advice." A number of respondents noted that referral systems are in place within the MOH and between NGOs and the MOH.

Senegal. Access to health services in Senegal is a constraint. With 52 health centers, or one per 150,000 inhabitants, Senegal falls far short of the WHO norm of one center per 50,000 inhabitants. The number of health posts has been steadily increasing since the adoption of primary health care. In 1994, there were 733 health posts, or one per 11,000 inhabitants, close to the WHO norm of one per 10,000. The 1995 situation analysis carried out by the Population Council and MSAS (1995) found that at least 79 percent of service delivery sites have water, electricity, a waiting room, and restrooms. Nonetheless, basic equipment is lacking in a large proportion of service delivery sites, including specula, gloves, blood pressure cuffs, and stethoscopes.

Peru. Peru's greatest challenge lies in providing clients with contraceptive choices and focusing on aspects of reproductive health beyond family planning. Although Peru has made significant progress in expanding access to services and improving the quality of care, many respondents felt that MINSA does not yet have a client orientation. For example, MINSA still does not fully incorporate gender concerns and cultural perspectives into its programs, nor does it always respect the reproductive and sexual rights of its clients. The recent reforms in the sterilization program are, however, a move in the right direction.

Another concern related to quality of care cited by many respondents is the attitude of health personnel. The constant refrain was the need for "*calidad* and *calidez*," or "quality and warmth," but especially warmth. Representatives of NGOs that work with women at community levels reported that personnel have received considerable training to improve their sensitivity but do not put the training into practice. "Women still complain about they way they are treated." One donor representative said that women's NGOs have been extremely important in monitoring quality of care, but a representative of a women's NGO said MINSA is not open to NGO input. "They demand proof, details before they will act, and [the NGO] does not have the capacity to provide that kind of information. The MINSA should do that kind of follow-up itself."

Because most health care providers are *mestizo*, the cultural gap between them and the populations they serve in heavily indigenous areas seriously affects the quality of care. Language barriers and health personnel's attitude of superiority prevent effective counseling and the client's free and informed choice of contraceptive method. Many respondents said that cultural misunderstandings are also a major obstacle to reducing maternal mortality. As one NGO respondent described, indigenous women prefer to give birth at home because the health posts do not follow traditional practices (giving mothers soup after childbirth, returning the placenta to them to be buried in the fields, etc.).

Some respondents cited logistical problems as barriers to reproductive health implementation. For example, clinics have experienced much difficulty in getting Pap test results back from laboratories and reporting the results to the patients. Supervision is a problem for some programs. For example, PROCETSS reports that it provides no supervision in the clinics, and therefore it does not know whether personnel are using the syndromic diagnosis of STDs in which they have been trained.

Addressing Legal, Regulatory, and Social Issues

In some countries, legal, regulatory, and social issues significantly affect implementation of reproductive health activities. Respondents highlighted a number of these issues.

Bangladesh. Bangladesh needs to address several legal and regulatory issues before it can fully implement the reproductive health approach. Some of these issues relate specifically to family planning. Clinical contraception is highly regulated in response to the efforts of the Bangladesh Medical Association. Tubal ligation is provided only under very strict conditions; for example, a woman must obtain spousal consent and already have a minimum of two children over one year of age. The process for securing approval for new contraceptives to be allowed into Bangladesh is difficult. In fact, restrictions even apply to methods that have undergone rigorous clinical testing abroad and are widely used in other countries.

Some people believe that it is not acceptable to provide contraception to certain groups of women. Although government documents discuss the provision of contraceptive services to adolescents, the unwritten but understood definition is "married adolescents." Moreover, some believe that it is not acceptable to provide contraception to adolescents regardless of marital status, even though the average

age at marriage for women is 18 and problems with pregnancy and delivery are more common among women of young maternal age.

India. In India, one of the most significant legal and regulatory issues impeding improved quality of care and expanded choice has been the failure to license new contraceptive methods, such as implants and injectables. The Indian system requires new drugs for licensing to undergo clinical trials and testing within India, a practice that delays the introduction of new methods. In the case of implants and injectables, the conservatism of the medical and government establishment combined with organized opposition from women's NGOs has effectively blocked the introduction of these methods. Another potential legal barrier to expanding the reproductive health approach relates to the means of dispensing STD medicines. If only doctors are allowed to treat clients with RTIs or STDs, ANMs will not be able to expand the potential coverage of RTI/STD services.

Nepal. Nepal faces some persistent legal and regulatory issues. Abortion is a criminal offence under any circumstances for both the provider and the woman who receives services, although a reproductive health advocate is promoting a bill on abortion that would allow for safe and legal abortion under extremely stringent guidelines. In addition, the MOH has been reticent to incorporate services for unmarried adolescents because provision of such services is considered a sensitive issue. One MOH official remarked, "Maybe adolescent reproductive health services are best left to the NGO community."

Jordan. Jordan is a conservative, predominantly Islamic society where men primarily are the decision makers in all aspects of family life, including use of family planning and reproductive health services. Even though Islam does not forbid the use of contraception, other reproductive health elements are sensitive subjects in Jordan, including postabortion care, STDs, and gender-based violence. Such a complex sociocultural context provides a challenge for policy formulation and provision of comprehensive reproductive health services. For example, one NGO respondent said, "There is even a need to have a postabortion care policy. This is not easy in Muslim countries." The NPC is recruiting religious leaders to promote family planning and reproductive health, and NGOs are initiating pilot projects aimed at increasing male involvement.

Ghana. The consensus among respondents in Ghana held that the nation's sociocultural context poses obstacles to the implementation of reproductive health policies and programs. Respondents mentioned pronatalism and gender roles, in particular. Several respondents believed, however, that the situation is changing and that people are now recognizing the costs of large families. A representative of a U.S. technical assistance organization said, "Society places a lot of value on many children—to show you are a man. I think these things are changing." Most respondents believed that the solution to the obstacle of male dominance as related to reproductive health lies in educating men about the reproductive health of both women and men and promoting use of services, particularly family planning. An MOH official said, "The major thing I consider is the male factor. All along it has more or less been sidelined. But if you take our situation in Ghana, it is so male-dominated. Even if a woman sees the need for family planning, she must get her husband's permission. There is a lot of evidence of women doing it on the quiet. Now how to get men to let women decide." Thus, in addition to empowering women to make their own decisions regarding contraception, it is crucial for men to understand the reproductive health benefits of family planning. One MOH respondent said, "Men seem to understand and agree when you talk to them, but when they go home [it is a different story]." Male attitudes are important in ensuring that women receive services, but men have reproductive health problems as well, such as impotency, STDs/HIV, and the need for contraception.

Senegal. While legal and regulatory barriers to reproductive health have been significantly reduced in recent years, respondents mentioned that several issues persist. Abortion is illegal in all cases, although one government respondent reported on a proposal for legalizing abortion in the case of rape or incest. A

respondent from a U.S. technical assistance organization noted that the very taboo against talking about abortion constrains efforts to promote postabortion care. Some respondents from U.S. technical assistance organizations said that a complete "juridical void" regarding AIDS has hampered efforts in AIDS prevention and treatment. Some laws have an inadvertent pronatalist effect, for example providing larger allowances to couples that have more children. Without a law that specifically authorizes health care providers to provide family planning services to adolescents, several respondents said that providers are reluctant to serve adolescents.

Several respondents also mentioned that health care is overly medicalized. Although some barriers in this area have been overcome, such as the requirement for laboratory tests before dispensing pills, others remain. For example, when nurses are not certified to insert an IUD, its availability is greatly reduced. Similarly, community workers cannot provide pills. As an MSAS respondent said, "Pharmacies are not the only opposition. You also need to convince politicians and health personnel," who tend to believe that pills should be distributed only by qualified medical personnel. This same respondent said that, in view of the extreme shortage of health personnel, it is particularly important to promote community-based distribution despite resistance by the medical establishment.

In addition to the general social conservatism that constrains program implementation, a variety of sociocultural factors inhibit demand for reproductive health programs. Women play a subordinate role in society and are therefore more likely than men to be uneducated, to control fewer resources, and to have less authority in decision making, all of which diminishes their ability to take care of their own reproductive health. A number of misconceptions also lower demand, such as the widespread perception that Islam forbids the use of contraception. A respondent from a U.S. technical assistance organization said that in the area of AIDS, one of the primary constraints is that the disease is not visible in Senegal—victims do not come out publicly—and so the public has begun to doubt that AIDS even exists.

Beyond the absence of policy on provision of contraception to youth and the fear of attack from the community, many health care providers do not provide family planning services to youth because of their own attitudes. One midwife respondent said that until a recent training course she would not provide family planning services to adolescents. "I used to think it wasn't good to give condoms to adolescents. Now I understand." Providers also frequently impose unnecessary constraints on contraceptive usage. As one respondent from a U.S. technical assistance organization said, "Whether or not laws exist for spousal and parental consent [for contraceptive usage], providers act as if there were."

Jamaica. The age of consent for adolescents in Jamaica is age 16; therefore, provision of contraceptives to youth under age 16 is technically illegal. An NGO representative noted, "We've been dealing with the age-at-consent issue for a long time. Now, if consensual sex is under age 23 [for the male], the judge has the discretion in sentencing. Before, if the female was 16 or below, there was a mandatory three-year jail sentence for the boy." The government is also trying to obtain special dispensation for providers to give contraceptive methods to adolescents.

To increase access to contraception, the government has been working to obtain over-the-counter status for pills. The effort gained approval and was scheduled to be gazetted by the government in early 1998. In addition, the government is attempting to increase access to contraceptives at new outlets. For example, when Pearl was the NFPB's socially marketed brand of pills, it had special dispensation to be sold in grocery stores and other retail outlets. Now that the private sector sells Pearl, the special dispensation no longer applies; however, women would like that convenience again.

Clarifying The Role of Donors

The role of donors came up in all eight countries. While respondents generally viewed donors favorably, many had concerns that donors push their own priorities in reproductive health and do not coordinate well among themselves.

Bangladesh. In Bangladesh, many respondents, including some donors, expressed dissatisfaction with the role that donors have been playing in both influencing and directing the process of policy development. One donor said that there are too many donors in Bangladesh, thus pulling the government in too many directions. Donors are trying to impose their own agendas on Bangladesh but keep changing those agendas. One donor representative said, "Maybe there is too much money here. All of the major international donors are here and it is a big business. Bangladesh has a big program, and the government and the NGOs can play donors against each other. This system sometimes leads to inefficiencies. For example, nutrition is not being addressed properly, and some donors are pushing family planning but not considering an integrated approach. They are also currently establishing a separate vertical HIV/AIDS program."

Nepal. More than half of the respondents in Nepal felt that there was a heavy reliance on donor funds and that the donors were pressing the reproductive health agenda. One NGO respondent stated, "The MOH is not in a position to dictate its terms to the donors, with the result different donors are committed to different subcomponents." A respondent from a U.S. technical assistance organization commented, "Donors are not consenting to the same definition of reproductive health." A member of the donor group commented, "Donor coordination is very weak. Donors are driving the program and pushing their own priorities." An MOH official mentioned, "Although the donors are putting in more resources, the MOH does not like the idea of providing a different subset of services in different regions."

Jordan. Some respondents reported that Jordan is heavily reliant on donor funds. One MOHHC respondent thought that funding levels are adequate but that donor funds for family planning and reproductive health should be allocated to the MOHHC instead of to NGO projects. Another MOHHC respondent commented that donors focus too heavily on family planning projects and that funds should be allocated to other areas of health as well. Respondents had different views on donor coordination. Some respondents noted that donor coordination was weak or nonexistent while others said that donor coordination was satisfactory.

Ghana. In Ghana, a new national budgeting system calls on donors to contribute to a common government fund. Various sectors, including health, are supposed to develop their programs irrespective of donor funding. According to an NPC respondent, "Then it becomes more country-driven than donor-driven," and the MOH coordinates donor funding in accordance with its own priorities. A government official said, "This way donors respect you more. They quickly find out if you don't [have a specific plan] and then they will push their own agenda." One donor, however, pointed out the major obstacle to this approach. "The problem is the bureaucratic methodology [of each donor] to be authorized to contribute. The virtue is that it is the MOH's plan. This shifts from donors funding the program. Parachuting in with a one-year program may not be the best. A community approach would help this."

Senegal. Some respondents in Senegal expressed the opinion that the disjointedness of donor interventions, particularly the division of regions among donors, has led to a fragmentation of the reproductive health program. Respondents generally agreed that for donors, the main priorities are family planning and AIDS. Indeed, several Senegalese respondents complained of donors' overemphasis on family planning and relative neglect of other health issues. While respondents generally agree that family planning is important, some pointed out that malaria is the number one cause of mortality but receives

much less donor attention. The *Population Strategy Document* (1997–2001) states that even within reproductive health, areas such as maternal mortality and infertility do not receive as much attention as they should. Some respondents expressed the view that STDs have become somewhat lost in all the attention to AIDS, and yet remain an important problem. One donor representative concurred, "Family planning and AIDS are oversubscribed by donors while other areas are neglected." Some respondents felt that, with the development of the national reproductive health program, donors will be forced to adapt to this programmatic approach and funding will be more likely to reflect government priorities.

Jamaica. Some respondents noted that the direction of programs in Jamaica tends to be driven by donor interests. A private sector representative said, "Projects tend to be driven by donors in these economic times. Now their emphasis is adolescents." A government representative added that the donor-driven approach to programs affects the ability of organizations to collaborate on activities. "We are donor-driven in the sense that there are timelines—agencies have to get the work finished in a certain amount of time—institutions don't have time to collaborate with other agencies in Jamaica." Respondents also mentioned coordination among donor agencies as a constraint. According to a private sector representative in Jamaica, "I'm a little disturbed by the lack of linkages among donor agencies. I can even see it working in the adolescent area. Everyone wants to be there first and be recognized most." An NGO representative added, "We need better integration of funding agencies and better collaboration. They have different policies and objectives, which leads to duplication."

Peru. Until three years ago, the vast majority of donor funding for reproductive health in Peru went to family planning, with a very small proportion allocated to other reproductive health services. A MINSA respondent affirmed that donor funding for other elements of reproductive health has been increasing since the ICPD, to the point that the agency now receives 50 percent of the funding allotted to family planning. In addition, new family planning projects have adopted a reproductive health focus. The perception persists, however, that donors' primary focus is family planning. Another MINSA respondent said, "They express an interest in other areas, but it doesn't translate into significant financial support." A respondent from a U.S. technical assistance organization working with youth said that donors are particularly eager to fund youth activities in Peru, in part because of the favorable political environment. Coordination among donors appears to be more informal than formal.

Maintaining a Long-Term Perspective

The final, and perhaps most important, message from the eight case studies is that change takes time. Respondents in many of the countries noted that only three years (at the time of the case study interviews) had elapsed since the 1994 ICPD, which is hardly sufficient time to determine if reproductive health policies and programs are succeeding. Many respondents said that despite the overwhelming challenges and some opposition to the new reproductive health orientation, the steps taken to implement reproductive health are proceeding in the right direction.

Bangladesh. An NGO representative in Bangladesh said, "Our accomplishments regarding reproductive health are difficult to judge at present because we have just started our journey. Reproductive health gives a new vision of the whole program through the emphasis on services for the entire family… Involving and organizing women has created mobility and higher aspirations among the poorest sector and shows that it is possible to achieve success in a society with high illiteracy and high infant and child mortality."

India. India is in the first stage of shifting its program to a reproductive health approach. The challenges faced by the program are enormous. Although reproductive health policy has been articulated, it will be

several years before judgments can be made on the success of the initiative. Yet, concrete steps to create more informed choice, meet individuals needs, improve quality, and develop a participatory process all seem to be leading the program in the appropriate direction.

Jordan. The policy formulation and implementation process in Jordan is a gradual one and, as a donor observed, "The tempo is very slow." Thus, three years after Cairo, the small strides made in Jordan in advancing reproductive health policies and programs give reason for relative optimism with respect to positive social and economic change.

Senegal. Several respondents commented that, in Senegal, building consensus is critical to implementing reproductive health programs. A respondent from a U.S. technical assistance organization said, "When someone is opposed, you cannot force him. You must engage in dialogue." Respondents were unanimous in the opinion that it is too soon to evaluate the impact of Senegal's new reproductive health focus, pointing out that only three years have passed since the ICPD. A donor respondent said that one lesson learned is that a new approach may be beneficial, but it may not necessarily be easy to implement. Reorienting services to reproductive health is a slow process, and no impact will be felt for some time. According to one respondent, "There is a danger that people will give up too soon, saying that reproductive health does not work and go back to the old approach."

Jamaica. In Jamaica, a government representative said, "In my experience, it takes years to make changes. We are making progress getting people to think about integration."

9. Summary and Conclusion

Many of the eight countries have achieved substantial progress in adopting and implementing the 1994 ICPD *Programme of Action.* While the conclusions reached here are based on only eight case studies, the assessment comprised all regions and included countries of varying sizes and economic development status. In addition, the assessment was based on a uniform methodology applied across the countries. Table A3 in the appendix summarizes the policy environment for reproductive health in the eight countries.

Table 2 scores the progress made by each of the eight countries for five stages toward implementation of the 1994 ICPD *Programme of Action.* The fives stages are not necessarily chronological; countries have generally addressed the stages simultaneously. Different countries have emphasized different stages to varying degrees depending on local circumstances. The results show that within their unique social, cultural, and programmatic contexts, countries have made significant progress in placing reproductive health on the national health agenda. All countries have adopted the Cairo definition of reproductive health either entirely or in part. Policy dialogue has occurred at the highest levels in all countries. The countries have also achieved considerable progress in broadening participation in reproductive health policymaking, although the results vary. Bangladesh, Senegal, and Ghana have been particularly effective in involving NGOs and civil society organizations in policy and program development. Placing reproductive rights on the agenda requires a continued effort in all countries.

The case studies indicate almost uniformly that countries are grappling with the issues of setting priorities, financing, and implementing reproductive health interventions. Bangladesh has made the greatest progress in these areas while India, Nepal, Ghana, Senegal, Jamaica, and Peru are beginning to take steps toward implementation of reproductive health activities. Jordan continues to focus primarily on family planning. As noted in the country analyses, all countries had included some elements of reproductive health services in their health and family planning programs before 1994.

From the perspective of donors and technical assistance agencies, Table 2 highlights two major areas that deserve attention in the near future. In India, Nepal, Jordan, Senegal, and Peru, the level of participation and political support for reproductive health may not be sufficient to advance easily to the next crucial stage of implementation. Continuing advocacy efforts and broadening the policymaking process would permit countries to move into program implementation more rapidly. It will be difficult for countries to make significant progress in implementation if they do not rank their reproductive health interventions and develop well-conceived plans for introducing or strengthening delivery of those services. Assuming that blanket implementation of the broad constellation of services called for in the ICPD *Programme of Action* is unlikely in the near future in most countries, the key to progress is setting priorities and phasing-in interventions, including making improvements in existing services. Further, budgeting, allocating resources to programs, and financing any additional reproductive health services cannot proceed effectively until countries have determined priorities for their reproductive health activities and planned for implementation.

In conclusion, based on the eight case studies, excellent progress has been made in placing the ICPD *Programme of Action* on national health agendas in the years since the Cairo conference, particularly in building support and broadening the processes that lead to policy change and program improvements. Despite many encouraging signs, limited progress has been achieved in actually implementing the *Programme of Action;* this finding is neither surprising nor unexpected. It took more than a generation to achieve the widespread adoption and implementation of family planning programs worldwide, and that task is far from complete. India will soon celebrate the 50-year anniversary of its family planning program, yet it still can point to tens of millions of underserved and potential users. To expect that countries in the short span of three and one-half years could build support for, adopt, and implement an expanded plan of reproductive health services is unrealistic. Progress to date is a logical beginning for defining and adopting reproductive health policies and principles and building political and popular support. The next critical stage is to help countries set priorities for reproductive health interventions and to develop budgets and craft strategies for implementing them.

Table 2. Progress toward Implementing the 1994 ICPD *Programme of Action* in Eight Countries, 1997

Country	Definition and Adoption of Reproductive Health ++ adopted ICPD + toward ICPD = same	Participation among Stakeholders in Policymaking and Program Planning ++ broad + partial = little	Support among Stakeholders for Reproductive Health ++ broad + partial = little	Setting Priorities among Reproductive Health Elements ++ fully set + partially set = no change	Implementation of Reproductive health Program ++ fully implemented + partially implemented = no/slight change	Efforts by Government to Mobilize Resources for Reproductive Health ++ strong + partial = little/ no change
Bangladesh	++	++	++	+	+	++
India	++	+	+	+	+	=
Nepal	++	=	=	=	+	=
Jordan	+	+	+	=	=	=
Ghana	++	++	++	+	+	=
Senegal	++	++	+	=	+	+
Jamaica	++	+	++	=	+	+
Peru	+	+	+	+	=	++

APPENDIX

Summary Tables of Reproductive Health Policies and Programs in Eight Countries, 1997

Table A1: Existence of Policies Covering Reproductive Health Components in Eight Countries, 1997

Components of Reproductive Health (RH)	Country							
	Bangladesh	**India**	**Nepal**	**Ghana**	**Senegal**	**Jordan**	**Jamaica**	**Peru**
Family planning	1973 National Population Policy	1952 National Population Policy, 1994 draft National Population Policy, 1996 RCH Policy	1996 RH Strategy; covers most components of RH	1994 National Population Policy, 1996 RH Service Policy and Standards, 1995 Vision 2020, 1996 Adolesecent RH Policy (draft)	1997 National Program for RH	1993 National Birth Spacing Policy, 1996 National Population Strategy	1995 Revised Population Policy, National Plan of Action on Population and Development (1995–2015)	1996 Program of RH (1996–2000)
Postabortion care	1997 RH Policy (draft)	1971 policy	1996 RH Strategy	1996 RH Service Policy and Standards	1997 National Program for RH	Not covered	Abortion illegal; postabortion care mentioned in Plan of Action (1995–2015)	1996 Program of RH (1996–2000)
Safe pregnancy	1997 RH Policy (draft)	1992 Child Survival and Safe Motherhood Policy	1996 RH Strategy	1994 National Population Policy, 1996 RH Service Policy and Standards	1997 National Program for RH	1996 National Population Strategy	Noted in 1995 Population Policy and Plan of Action (1995–2015)	1996 Program of RH (1996–2000)
RTIs	1997 RH Policy (draft)	1996 RCH Policy	1995 National Policy covers STIs/HIV/AIDS	1996 RH Service Policy and Standards, 1996 Adolescent RH Policy (draft)	1997 National Program for RH	Not covered	Noted in Plan of Action (1995–2015)	1996 Program of RH (1996–2000)

Table A1: Existence of Policies Covering Reproductive Health Components in Eight Countries, 1997

Components of Reproductive Health (RH)	Country							
	Bangladesh	**India**	**Nepal**	**Ghana**	**Senegal**	**Jordan**	**Jamaica**	**Peru**
STDs	1997 RH Policy (draft)	1996 RCH Policy	1995 National Policy covers STIs/HIV/AIDS	1992 Guidelines for AIDs Prevention and Control, 1994 Population Policy, 1996 RH Service Policy and Standards, 1997 National Policy on AIDS (draft), 1996 Adolescent RH Policy (draft)	1997 National Program for RH	Not covered	No national policy; strong STD/AIDS program	Not covered
HIV/AIDS	1997 HIV/AIDS Policy	1997 policy	1995 National Policy covers STIs/HIV/AIDS	1992 Guidelines for AIDs Prevention and Control, 1994 National Population Policy, 1996 RH Service Policy and Standards, 1997 National Policy on AIDS (draft), 1996 Adolescent RH Policy (draft), 1995 Vision 2020	1997 National Program for RH	Not covered	No national policy; strong STD/AIDS program	1989 AIDS Control Program
RH services for adolescents	1997 RH Policy (draft)	1997 Youth Policy (draft)	No national policy; mentioned in the RH Strategy	1996 RH Service Policy and Standards, 1996 Adolescent RH Policy (draft)	1997 National Program for RH	Not covered	Being drafted; noted in Plan of Action (1995–2015)	1996 Program of RH (1996–2000)

Table A1: Existence of Policies Covering Reproductive Health Components in Eight Countries, 1997

Components of Reproductive Health (RH)	Country							
	Bangladesh	**India**	**Nepal**	**Ghana**	**Senegal**	**Jordan**	**Jamaica**	**Peru**
Maternal and infant nutrition	1997 RH Policy (draft)	1992 Child Survival and Safe Motherhood Policy	Maternal nutrition mentioned under RH Strategy Child health covered by separate division of MOH	1996 RH Service Policy and Standards, 1995 Vision 2020.	1997 National Program for RH	1993 National Birth Spacing Policy, 1996 National Population Strategy, 1993 National Plan of Action for Childhood	Noted in Plan of Action (1995–2015)	Not covered
Cancers of the reproductive tract	Not covered	Not covered	Covered	1996 RH Service Policy and Standards	1997 National Program for RH	Not covered	Noted in Plan of Action (1995–2015)	1996 Program of RH (1996–2000)
Infertility	Not covered	Not covered	Covered	1996 RH Service Policy and Standards	1997 National Program for RH	Not covered	Noted in Plan of Action (1995–2015)	1996 Program of RH (1996–2000)
Female genital mutilation	NA	NA	NA	1994 Female Genital Mutilation Law, 1996 RH Service Policy and Standards, 1996 Adolescent RH Policy (draft)	1997 National Program for RH	NA	NA	NA
Gender-based violence	Cruelty to Women Act 1997	Not covered	NA	1996 Adolescent RH Policy (draft) (Violence against adolescents and bias against girl-child)	1997 National Program for RH	Not covered	1995 Violence against Persons Act	1996 Plan Nacional de Accion Mujer y Desarrollo

NA= not applicable.

Table A2: Stage of Implementation of Components of Reproductive Health Programs in Eight Countries, 1997

Component of Reproductive Health	Country							
	Bangladesh	**India**	**Nepal**	**Ghana**	**Senegal**	**Jordan**	**Jamaica**	**Peru**
Family planning	National	Program implemented; now shifting to target-free FP services; more emphasis on short-term methods	RH strategy formulated in 1996 and officially adopted in February 1998 not disseminated or implemented for any of its components FP norms and guidelines published in 1996 and disseminated to all providers	National	Services available in government, NGO, and private sectors; no community-based distribution, limited social marketing	National; services available in government/ NGO and private sectors	Services available through MOH/PHC/ MCH, NFPB, NGOs, private providers, social marketing No changes in government FP program since ICPD; FAMPLAN expanding to RH services Revising service delivery guidelines	Services available in government, NGO, and private sectors; sterilization legalized in 1995 and added to government program
Postabortion care	Planned	Program implemented	No formal guidelines; abortion is a criminal procedure in Nepal; postabortion care pilot project was set up at the National Maternity Hospital (funded by USAID)	Planned; some training of midwives and physicians	Pilot operations research project getting started	Services available in some government and private sector hospitals and clinics	Services available through MOH/ PHC/MCH, some NGOs and private providers	Small initiative in some hospitals

Table A2: Stage of Implementation of Components of Reproductive Health Programs in Eight Countries, 1997

Component of Reproductive Health	Country							
	Bangladesh	**India**	**Nepal**	**Ghana**	**Senegal**	**Jordan**	**Jamaica**	**Peru**
Safe pregnancy	Planned	Program implemented	National cell established within Family Health Division Safe pregnancy pilot projects run by donors within different districts	National	Services available in government, NGO, and private sectors	National; services available in government, NGO, and private sectors	Services available through MOH/ PHC/MCH, some NGOs, and private providers Updating service delivery guidelines for MCH services	Prenatal, delivery, and postnatal services in the public and private sectors; "Emergency Plan for the Reduction of Maternal Mortality" launched in 1996
RTIs	Planned	Planned under RCH program	Falls under National AIDS/STD Center Policies implemented slowly AIDSCAP has programs along the Nepal-India border for high-risk populations	National, but not all levels of providers have been trained	Services available through the private sector, in public sector hospitals, and in some health centers; training of public sector staff in treating RTIs is planned	National; services available in government, NGO, and private sectors; most clients served in private sector	Services available through MOH/PHC/ MCH and MOH/ secondary care and MOH/Epidemi-ology Unit (EPI), which runs the STD/AIDS program	No program but treats whoever walks in

Table A2: Stage of Implementation of Components of Reproductive Health Programs in Eight Countries, 1997

Component of Reproductive Health	Country							
	Bangladesh	**India**	**Nepal**	**Ghana**	**Senegal**	**Jordan**	**Jamaica**	**Peru**
STDs	Planned	Planned under RCH program	As above	National, but not all levels of providers have been trained	Norms for the syndromic diagnosis and treatment of STDs developed and staff trained, but norms not yet integrated into MSAS's flow chart	National; services available in government, NGO, and private sectors; most clients served in private sector	Strong STD/AIDS program through MOH/EPI	Program implemented
HIV/AIDS	Planned	Program implemented through the National AIDS Coordinating Organization (NACO)	As above	National; concentration on education	National AIDS Control Program established in 1990; IEC campaign, but limited condom promotion	Services available in public and private sectors; education in public, NGO and private sectors; most clients served in private sector	Strong STD/AIDS program through MOH/EPI	Program implemented

Table A2: Stage of Implementation of Components of Reproductive Health Programs in Eight Countries, 1997

Component of Reproductive Health	Country							
	Bangladesh	**India**	**Nepal**	**Ghana**	**Senegal**	**Jordan**	**Jamaica**	**Peru**
RH services for adolescents	Planned, married adolescents only	Policy development stage	IPPF affiliate has several youth programs that address young adult reproductive health, vocational training, and skill building Provision of comprehensive RH services for youth mentioned in the RH Strategy, but the MOH is not taking any steps in that direction	National; concentration on education	Many projects and agencies involved; IEC programs for youth in place for years, just beginning projects that offer services to youth; new focus on out-of school youth	Not covered in public sector; NGOs involved in education	A high priority for Jamaica; working on USAID-funded Adolescent Upliftment Project; UNFPA designing a project; USAID designing another project	Implemented in some regions
Maternal and infant nutrition	National, but not well implemented; planned under RH	Program being implemented	Programs for anemia and breastfeeding ongoing as a component of the MCH program	National	Breastfeeding, growth monitoring, diarrhea control, and prevention of anemia included in minimum package of services at health posts; National Program for Control of Malnutrition and National Program for Community Nutrition	National; services available in government, NGO, and private sectors	Noted in Plan of Action (1995–2015); not sure about program activities	No information

Table A2: Stage of Implementation of Components of Reproductive Health Programs in Eight Countries, 1997

Component of Reproductive Health	Country							
	Bangladesh	**India**	**Nepal**	**Ghana**	**Senegal**	**Jordan**	**Jamaica**	**Peru**
Cancers of the reproductive tract	Not addressed	Not addressed	Mentioned in the RH Strategy; however, programs for screening and treatment available only in urban centers like Kathmandu	Planned, presently teach breast self-exami-nation	Addressed in national program, but few services are available	National; services available in government, NGO, and private sectors	Covered through MOH/PHC/ MCH centers (not at all levels) and MOH/ secondary care and private providers	Program being planned
Infertility	Not addressed	Not addressed	Mentioned as a component of RH package in the strategy Plans to initiate services for infertility, mostly through education for prevention of infertility Plans to upgrade district hospitals to be able to diagnose and treat /refer	National counseling, some private hospitals have in-vitro fertilization	Addressed primarily through the public sector, mainly through STD control	In public sector, in Royal Medical Service Hospital only; in private sector, including University of Jordan Hospital	New infertility center opening at the University of the West Indies; private providers and NGOs work in this area	No program
Female genital mutilation	NA	NA	NA	National	NGOs and MFEF working to raise awareness mostly through new initiatives	NA	NA	NA

Table A2: Stage of Implementation of Components of Reproductive Health Programs in Eight Countries, 1997

Component of Reproductive Health	Country							
	Bangladesh	**India**	**Nepal**	**Ghana**	**Senegal**	**Jordan**	**Jamaica**	**Peru**
Gender-based violence	Draft statute	Not addressed through RCH program	Not included in the RH definition	Not addressed	Addressed in PAIP, but no program currently being implemented	Not specifically addressed; counseling if clients request	Some links between MOH and rape unit of police Bureau of Women's Affairs and women's NGOs working on component FAMPLAN starting a project in 1998	Program implemented, but weak
Integrated services	All but cancer and infertility; national government program	Integration of FP, safe motherhood, abortion, child survival, and STD services planned through the RCH program in some districts	Plans to integrate all components except gender-based violence and possibly special adolescent services	National, service integration not complete; referral systems in place	Planning to integrate all components at central level; some pilot projects have integrated services	Components of RH not well integrated in MOHHC; NGO services better integrated	MCH and FP integrated; considering integration of FP and RTI/STD/ AIDS programs; pilot project in North-east region; FAMPLAN has successful integration program	FP, cancer, maternal health, and youth integrated at MOH central level; STD/AIDS separate; service delivery in health centers link components of RH.

Table A3: Policy Environment for Implementing Reproductive Health Programs in Eight Countries, 1997

Component of Policy Environment	Country							
	Bangladesh	**India**	**Nepal**	**Ghana**	**Senegal**	**Jordan**	**Jamaica**	**Peru**
Level of participation in RH policy/program development from								
Government ministries (other than MOH)	High	High	Low	Medium/high	High	Low	High	Medium
RH NGOs	High	Medium	Medium	High	High	Medium	Medium	Medium
Women's advocacy groups	Medium	Medium	Low	High	Low	Medium/high	Low	Medium
Religious leaders	Low	None	None	Medium	Low	Medium	None	None
Community leaders	Low	None	Low	Medium/high	Low	Low	None	Medium
University	—	—	—	High	—	High	Medium	—
Level of support for RH from political leaders								
President/prime minister/king	High	Low	Low	Medium	Medium	Low	High	Medium
Parliament/ministers	High	Low	Low	Low	Medium	Low/medium[3]	High	Medium
Level of support and influence for RH from religious leaders								
Support	Medium	Low	Low	Medium	Medium	Medium	Medium	Low
Influence	Low	Medium	Low	Medium	High	High	Low	Medium
RH implementation plans exist								
National	Yes, 1997	Yes, 1996	Yes, 1996	Yes	Yes	No	No	Yes
Subnational	Yes, 1997	Yes, 1996	No	Yes	Yes	No	No	Not sure
Structure for RH program								
Integrated	Planned program is integrated at service delivery level	Integrated, except NACO, which deals with HIV/ AIDS/STDs	Integrated with HIV/AIDS	Integrated, mostly FP and MCH with STDs and postabortion care	Integration in progress	NGOs have integrated services; government has vertical services	FP/MCH integrated; STD/AIDS may be integrated with FP/MCH	FP, youth, cancer, maternal health integrated; STD/AIDS separate
Vertical								

Table A3: Policy Environment for Implementing Reproductive Health Programs in Eight Countries, 1997

Component of Policy Environment	Country							
	Bangladesh	**India**	**Nepal**	**Ghana**	**Senegal**	**Jordan**	**Jamaica**	**Peru**
Health care providers have knowledge of RH policy and program components								
Public sector	Few	Most	Some	Some	Most	Some	Few	Most
Private sector	Some	A few	Few	Some	Some	Some	Few	Some
NGOs	Most	Most	Most	Most	Most	Most	Some	Most
Health care providers have training in RH components								
Public sector	Few	Some	Some[1]	Some	Most	Few	Few	Most
Private sector	Most	A few	Few	Some	Some	Some	Few	Some
NGOs	Most	Some	Some	Some	Most	Some	Some	Most
Resources allocated for RH have increased as a result of 1994 ICPD in the								
Public sector	Yes	No	No[2]	Yes	Yes	No	Not sure[4]	Yes
Private sector	No	No	No	Yes	No	No	No	No
NGOs	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes
Donors	Yes	No	Yes	Yes	Yes	Yes	No	Yes
Resources for RH program implementation are sufficient	Yes for components in program	No for most components	No for most components	No for most components	No	No	No for most components	No
Percent of resources for RH program implementation that are national (level of reliance on donor funds for RH)	27% of program budget; 90% of salary budget	89% in 1987 85% in 1996	No clear response	No clear response	Likely high	No clear response	Program staff not sure if government budget allocation to RH components is increasing	Medium to low

[1] They are trained in the components but will need upgraded skills under the new RH Strategy.

[2] The resources are unchanged, but the budget allocation is now for RH not MCH.
[3] The support of the Minister of Health is medium.
[4] Program staff not sure if government budget allocation to RH components is increasing. Donor assistance has been reduced over the past five years. The government has picked up the cost of contraceptives during the USAID phase-out (ending in 1998). Donors are now funding adolescent RH activities.

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